Decriminalization of drug use in the context of HIV: a guidance note

Creating an enabling legal environment for the HIV response for people who use drugs

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DCR	drug consumption rooms
HCV	hepatitis C virus
UNHRC	United Nations Human Rights Council
INCB	International Narcotics Control Board
INPUD	International Network of People who Use Drugs
LGBTQIA+	lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual individuals
NSP	needle and syringe programme
OAMT	opioid agonist maintenance treatment
OHCHR	Office of the United Nations High Commissioner for Human Rights
PCB	UNAIDS Programme Coordinating Board
STI	sexually transmitted infection
TQ	threshold quantity
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGA	United Nations General Assembly
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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Executive summary

People who use drugs are disproportionately impacted by the HIV epidemic. In 2022, the risk of acquiring HIV for people who inject drugs was 14 times that of the rest of the adult population *(1)*. Harm reduction services, including needle and syringe programmes and opioid agonist maintenance treatment (OAMT), have been proven time and again to be effective in significantly reducing the risk of acquiring HIV, viral hepatitis and other blood-borne viruses *(2-6)*. Access to HIV testing and treatment can enable people living with HIV to reduce their viral load to undetectable, preventing sexual transmission of HIV, with a life expectancy similar to that of the rest of the general population *(7,8)*.

However, criminalization of drug use and possession for personal use, as well as related minor offences such as possession of drug related paraphernalia, have been repeatedly shown to undermine harm reduction efforts and increase stigma and discrimination and the risk of acquiring HIV. Criminalization of drug use and possession for personal use, along with law enforcement practices, is associated with higher rates of needle sharing, lower engagement with needle–syringe programmes and higher HIV incidence and prevalence *(9–10)*.

The decriminalization of drug use and possession for personal use, when implemented effectively, is a critical element in a human rights and public health-based HIV response. It can reduce stigma, improve access to harm reduction services, and facilitate engagement with HIV care. A growing number of countries are implementing models of decriminalization.

The group of countries that have adopted decriminalization models spans all continents. Some countries have had decriminalization of drug use and possession for personal use in place since the 1980s *(11)*. Each approach is slightly different and the way in which decriminalization can support the HIV response or undermine it, in some cases repeating the harms of criminalization.

This document brings together different approaches to and experiences of decriminalization of drug use and possession for personal use and provides recommendations for countries to ensure an enabling environment for the HIV response.

International commitments, laws, norms and standards relating to decriminalization of drug use and possession for personal use

The decriminalization of drug use and possession for personal use has been called for by a wide range of international human rights and public health bodies as a key element in ending AIDS as a public health threat and fulfilling broader health and human rights commitments. The 2021 Political Declaration on HIV/AIDS calls for the removal of harmful restrictive and discriminatory laws that create barriers to

HIV services *(12)*. In line with this, the Global AIDS Strategy 2021–2026 includes a specific target that by 2025 less than 10% of countries will have laws criminalizing the possession of small amounts of drugs *(13)*.

In terms of drug policy, the three United Nations (UN) drug conventions *(14)*[1] provide the framework for the international approach to drug policy, with State parties to the conventions required to implement the measures contained within the conventions. The overarching concern of the UN drug conventions is the health and welfare of mankind. As noted by UNODC, while the conventions do not mention decriminalization of drug use and possession for personal use, it is not inconsistent with the obligations of the conventions, stating "recognizing drug use and drug use disorders as a public health concern that require responses that are health-centred and less reliant on punitive sanctions is entirely consistent with what is foreseen in the international drug control framework" *(14,15)*.

International human rights bodies and special procedures have likewise recommended the decriminalization of drug use and possession for personal use in order to meet international human rights commitments, including the Committee on Economic, Social and Cultural Rights, the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the UN Working Group on Arbitrary Detention *(16–20)*.

The UN System Common Position on Drug Policy recognizes the importance of developing alternatives to conviction and punishment, including decriminalization of drug possession for personal use *(21)*. UNAIDS, UNDP, WHO and OHCHR have all recommended the decriminalization of drug use and possession for personal use as critical to the HIV response *(22-27)*. The International Guidelines on Human Rights and Drug Policy *(International Guidelines)*, published in 2019 by these agencies, along with the International Centre for Human Rights and Drug Policy, make it clear that under international human rights law states may "utilise the available flexibilities in the UN drug control conventions to decriminalise the possession, purchase, or cultivation of controlled substances for personal consumption"*(28)*.

What is meant by decriminalization?

Decriminalization refers to a process, the end result of which is that a particular act is no longer considered a criminal offence—for example, by removal from the criminal code—and does not attract criminal penalties. Administrative consequences, such as a fine or referral to treatment, may be imposed instead, though they are not present in all decriminalization models. It is distinct from depenalization wherein the act remains criminalized, meaning no legislative reform is required, but there is a reduction in the use of existing criminal sanctions.. It is also distinct from legalization which explicitly permits non-medical supply and use of drugs and establishes a formal regulatory framework for that purpose *(15, 29,30)*.

1 The Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol; the Convention on Psychotropic Substances of 1971; and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

In relation to drug policy within the scope of this document, decriminalization refers to the removal of criminal penalties for drug use and possession for personal use as well as other minor drug-related offences. In the *Guidance note*, "decriminalization of drug use and possession for personal use" is used to refer to the decriminalization of personal drug use, possession of drugs for personal use as well as other minor offences related to personal drug use such as the provision or possession of drug related paraphernalia, such as needles and syringes.

Purpose, scope and methodology

The G*uidance note* pulls together the lessons learned from different models and approaches to the decriminalization of drug use and possession for personal use, analysing their efficacy in relation to HIV outcomes. It is intended to support countries to develop effective, public health and rights-based models of decriminalization in the context of HIV. It provides key principles and good practices from the various models reviewed, as well as the experiences and expertise of people who use drugs, academics, health service providers and other experts.

To produce the G*uidance note*, a range of methods were used, including legal and policy reviews, surveys distributed to country and regional offices and community and expert consultations. These consultations were led by INPUD and provided in-depth insight from the community of people who use drugs, civil society groups, UN country teams and an international advisory community of drug policy experts. Their expertise, and crucially the expertise of people with lived and living experience, was essential for ensuring an accurate reflection on the lives of people who use drugs and the effects of drug policy.

Foundational principles

The ***Guidance note*** outlines several foundational principles for the decriminalization of drug use and possession for personal use. In developing and implementing decriminalization models it is essential to ensure:

- A human rights-based approach.
- A public health approach including an enabling legal environment for the HIV response and removal of sanctions.
- Bodily autonomy, voluntary informed consent and no coercion.
- Non-discrimination.
- Meaningful participation.
- Transparent and accountable systems.
- Decriminalization of the use and possession for personal use of all drugs.
- The decriminalization of drug use and possession for personal use as part of a broader health and rights approach including
    - Addressing underlying determinants of health.
    - Addressing stigma and discrimination.
    - Provision of harm reduction services.

Decriminalization models

Effective decriminalization models vary across jurisdictions but share a number of common considerations. Key among these are:

1. Defining 'for personal use'–including the role of threshold quantities and other approaches.
2. The role of law enforcement, judiciary and other actors in a decriminalization model.
3. Alternatives to criminal sanctions.

Defining for personal use

When decriminalizing drug use and possession for personal use, a key consideration is how to differentiate between individuals possessing drugs for their own personal use, versus those possessing drugs with intent to produce,

supply, sell or traffic for profit. Following both human rights and criminal law principles, the assumption of innocence until proven guilty must be maintained.

Many countries use threshold quantities, other jurisdictions may simply say 'small amount' while others may not have limits at all but rely solely on other elements, such as whether there is evidence of criminal activity *(31)*.

If implemented well, evidence from communities and implementation reviews indicates indicative or non-binding threshold quantities can provide clarity in the legal framework, both for people who use drugs and those responsible for determining the offence (for example, the police), thereby reducing the risk of discriminatory, arbitrary, inconsistent or unfair decisions and unnecessary interactions with law enforcement and the courts. A flexible approach, where additional evidence of criminal activity is still required in addition to possessing quantities over the threshold, appears to function better than stricter approaches to quantities.

Who determines the offence and who decides the consequences?

Determination of the offence relates to the decision-making powers of various actors in the criminal justice system. For most countries across the world that have ended criminal sanctions for specific drug-related activities, the decision-maker will usually either be the police, the prosecutor and/or the judiciary *(32,33)*.

The chosen approach here can have significant impacts on HIV and other health and human rights outcomes. Evidence has shown that mere interaction with law enforcement can impact on health-seeking behaviours, so the extent to which a person is able to reduce police contact is important *(10)*. At the same time, an advantage of police-led models is that decisions can be made early, with people who are caught in possession of drugs experiencing less in-depth contact with the criminal justice system. As such, unnecessary interactions should be limited, including removal of practices such as stop and search, with comprehensive training for law enforcement officers and strong oversight mechanisms.

Alternatives to criminal sanctions

When criminal laws and sanctions are removed, the question often remains as to what, if anything, to put in their place, whether it be administrative sanctions, health responses or no response at all. Each has its own implications in relation to health and human rights, with some approaches replicating the harmful impacts of criminalization. Decisions in this regard should be based on public health evidence, human rights law and in consultation with communities.

There is no evidence that punishing someone deters drug use *(29)*. Some sanctions or punishments undermine public health and are in contravention of human rights obligations, ultimately replicating the harms of criminalization. A no-sanctions model with offers for voluntary treatment appears to have the best chance of positive public health and human rights outcomes.

Additional considerations

- **Expungement of criminal records.** Given the stigma that can be associated with a criminal record, and the barriers it can place on rights to non-discrimination in employment, access to social and economic rights, including access to housing or education or on international mobility, expungement is an important element in the decriminalization process
- **Drug paraphernalia laws.** Criminalizing the possession of harm reduction equipment such as needles and syringes undermines HIV prevention efforts.
- **Youth-friendly services.** Adolescents and young people must have access to non-discriminatory, age-appropriate harm reduction and HIV services. They should not be criminalized nor be removed from their educational institutions for any drug-related activity.
- **Public drug use.** Criminalization or administrative consequences for public drug use has a disproportionate impact on people who are already marginalized, thus leading to disproportionate targeting by law enforcement. Ensuring spaces to use drugs safely is critical to improving HIV outcomes as well as protecting people's right to health.
- **Social determinants of health.** Addressing factors such as housing, employment and social inclusion is essential for improving health outcomes.

Good practice principles

Overarching:

- Alternatives to criminalization and incarceration should be developed using a human rights and public health-based approach.
- People who use drugs should be supported, including financially, to participate meaningfully in the development, implementation and monitoring of the decriminalization of drug use and possession for personal use.
- To ensure decriminalization and harm reduction services are intersectional, policies and practices need to address the diverse and overlapping identities and experiences of people affected by drug laws and drug-related harm. This is in recognition that drug policies disproportionately affect marginalized groups, including people of colour, lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual individuals (LGBTQIA+), sex workers, racialized communities, women, young people, people living with HIV, people with disabilities and economically disadvantaged communities.
- Decriminalization efforts relating to people who use drugs should seek to remove all criminal penalties for minor non-violent drug offences that, in review with communities, have been identified as undermining the HIV response and broader public health efforts, including but not limited to drug use, possession for personal use, possession of drug-related paraphernalia.
- In parallel with the decriminalization of drug use and possession for personal use, investment must be made in the provision of affordable, accessible, acceptable and good quality harm reduction services and evidence-based treatment that are non-discriminatory in line with the WHO recommended package of interventions.
- Address underlying social determinants of health, including housing, work, social protection educational opportunities and family support.

Determining personal use

- The criteria for distinguishing between drug possession for personal use and possession for supply for profit should create certainty and clarity among people who use drugs and for the criminal justice system.
- In the development of any threshold quantities or other methods for determining use versus supply:
  - The diversity of needs and experiences of people who use drugs, including diversity in quantities and types of drugs consumed, should be taken into account.
  - The health and wellbeing of people who use drugs, including ability to control when and how they both acquire and consume drugs, and their ability to source and utilize sterile injecting equipment, must be protected.
  - People who use drugs must be able to understand the criteria for personal use and to know whether or not they fall within those criteria.
  - Threshold quantities must not disadvantage or discriminate against people based on, for example, their tolerance, dependence, frequency of use or rural location.
- The basic principles of criminal law must be respected.
  - People should be protected from arbitrary detention.
  - The use of threshold quantities is a preferable to no limits or vague limits,

providing greater legal certainty for people using drugs.

- The establishment of threshold quantities, and how they are used, must be established following meaningful consultation with communities of people using drugs, particularly those using drugs dependently or those who need to bulk purchase due to difficulties in accessing drug markets.
- Threshold quantities should be set at a sufficiently high level to avoid creating risk behaviours such as rushed consumption/injection or needle sharing. They should be based on weight only to ensure people who use drugs can control whether they are within the threshold quantities.
- Threshold quantities should be indicative. Possession of drugs above the threshold amount should not be considered criminal activity without additional evidence (a floor not a ceiling approach).
- Law enforcement should be trained on how threshold quantities work, including that amounts above the threshold quantities are not proof of supply and should not be used as a basis to bring a prosecution.

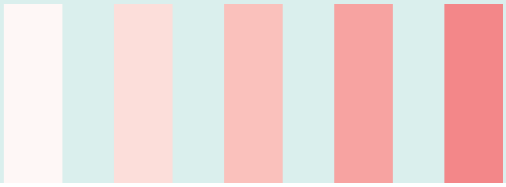
Who determines the offence and who decides the consequences?

- The minimization of contact with law enforcement, as well as with the criminal justice system generally, should be prioritized to reduce harms, including to the HIV response. Decisions on whether someone falls within the legal framework should be made as early as possible, in most cases within minutes where evidence is clear.
- Possession of drugs for personal use or possession of drug-related paraphernalia should not attract the attention of law enforcement.
- Limit powers to stop and search to cases where there are reasonable grounds to suspect criminal activity such as intent to supply for financial gain.
- Diversion from criminal processes and sanctions should happen early to avoid lengthy delays, pre-trial detention and unnecessary, possibly costly, interactions with the criminal justice system.
- Where police have decision-making power in relation to drug possession and use, there should be clear accountability, oversight and reporting systems developed and implemented in collaboration with community-led organizations to monitor and address discriminatory practices, potential net-widening and potential corrupt practices.
- Comprehensive training, sensitization and awareness raising among relevant public authorities, including police, should be provided to ensure effective implementation and adherence to relevant decriminalization policies and enable people who use drugs to feel comfortable seeking the assistance of law enforcement if needed.

Alternatives to criminal sanctions

- Any State response to the possession of drugs for personal use must support public health outcomes, comply with human rights obligations and not recreate the harms of criminalization.
- A no-sanction model removes barriers for people to access health and social support and improves their health and wellbeing and can help facilitate effective HIV responses and respect the rights of people who use drugs.
- Police and judicial system interaction should be minimized where possible.
- Confiscation of drugs and drug-related paraphernalia should be avoided as this can increase health harms and undermine law enforcement efforts as it contributes to rushed drug consumption and needle sharing.

- In models where penalties do exist, suspension of proceedings, with no further action after a short, specified period, should be incorporated.
- Where administrative sanctions are used, such as fines, they should not recreate the harms of criminalization or disproportionately affect certain groups, particularly those already marginalized.
- Referrals to treatment should be voluntary and only be used where treatment is readily available.
- Treatment plans and progress should be based on public health evidence and meet international human rights obligations of confidentiality and be overseen by health professionals only.
- Mandatory treatment, including but not limited to where it takes place in a detention setting, should be prohibited as this contravenes States' human rights obligations. Mandatory or coerced treatment is arbitrary in nature and operates in the absence of consent given freely, which is also contrary to the right to health.
- Escalated approaches, i.e. more severe sanctions for repeated offences, should not be adopted as this penalizes people who are caught repeatedly in possession of drugs, which will often be people who experience drug dependency.
- Non-compliance with any penalty under a decriminalized model should not lead to more serious proceedings, including criminal prosecution for non-compliance, or create barriers to accessing harm reduction services.
- Administrative sanctions or treatment requirements should be monitored and reviewed regularly to ensure they support human rights and public health outcomes.



Drug-related paraphernalia

- People who use drugs must not be criminalized for using or possessing drug-related equipment, including indirectly by having their equipment tested for drug residue or being targeted for discarding used equipment beyond ordinary littering laws.
- Supply of harm reduction equipment should be legal.
- The use of civil laws to prohibit the carrying of drug paraphernalia should also be abolished in recognition that this can undermine public health goals.

Expungement of criminal records

- Countries considering the decriminalization of drug use and possession for personal use should introduce a process to review convictions and sentences for such offences and, where appropriate, quash, commute or reduce existing convictions and/or sentences.

Public drug use

- Public drug use should not be a crime, nor should it be punished as a civil offence. Rather, support for the creation of spaces, such as drug consumption rooms (DCR) should be prioritized, as well as addressing underlying causes of precarious housing situations.

Young people

- Children and adolescents should not be criminalized for drug use or possession for personal use. Adolescents who have reached the age of criminal responsibility should benefit from decriminalization models.
- Students should not be expelled from school for any drug-related activity and any treatment should be voluntary.
- Harm reduction services should be available to adolescents and young people and should be youth-specific.

Introduction

The *Decriminalization of drug use in the context of HIV: a guidance note* (*Guidance note*) is an initiative led by UNAIDS in partnership with UNDP and INPUD to support countries to achieve the Sustainable Development Goal of ending AIDS as a public health threat by 2030 for everyone.

The *Guidance note* is intended to serve as a resource for countries, donors, communities and stakeholders committed to creating an enabling legal environment for people who use drugs in the HIV response by reviewing and reforming restrictive legal and policy frameworks, including discriminatory laws and practices that create barriers to accessing HIV services or reinforce stigma and discrimination, as committed to in the UN General Assembly (UNGA) 2021 Political Declaration on HIV and AIDS *(12)*. These commitments are also found in the Global AIDS Strategy 2021–2026 which aims to support global efforts to ensure that by 2025, less than 10% of countries continue to criminalize same-sex sexual activity, the possession of small amounts of drugs, sex work, or HIV exposure, non-disclosure and transmission *(13)*. At the time of writing, this target is recommended to be included in the 2030 targets for the Global AIDS Strategy 2026–2031 *(34)*.

Ending AIDS as a public health threat by 2030 requires an approach grounded in human rights, public health, community and evidence. Criminalization of drug use and possession has proven to be a major barrier to effective HIV prevention and treatment. Research consistently demonstrates that punitive drug policies drive stigma, increase health risks and limit provision of and access to harm reduction services, exacerbating the HIV epidemic *(9, 10)*. Global human rights standards and international legal frameworks provide the flexibility for States to decriminalize drug possession while maintaining their obligations under UN drug control treaties *(15, 28)*.

People who inject drugs are disproportionately affected by HIV. Globally in 2022, they were 14 times more likely to acquire HIV than the general adult (15–49) population and 8% of new HIV infections occurred within this group *(1)*. Criminalization fosters environments of discrimination, economic insecurity and incarceration—factors that heighten the risk of HIV transmission and undermine public health efforts.

Decriminalization of drug use and possession for personal use is recognized as a societal enabler for HIV response and a critical enabler in the WHO guidelines for key populations in the HIV response *(13, 26)*. The decriminalization of drug use and possession for personal use, when combined with harm reduction strategies, improves HIV and other health outcomes, facilitates greater engagement in prevention and treatment services and reduces HIV transmission rates *(35)*.

Evidence highlights that criminalization contributes to:

- Higher HIV prevalence among people who inject drugs.
- Increased sharing of injecting equipment due to fear of law enforcement.
- Reduced access to sterile needles, syringes and opioid agonist maintenance treatment (OAMT).
- Avoidance or delay in seeking health care, HIV testing and treatment due to fear of arrest, stigma or discrimination.
- Increased rates of overdose and other coinfections such as viral hepatitis.
- A greater burden on criminal justice systems, leading to high incarceration rates without addressing underlying health and social needs.

In accordance with international human rights standards and public health evidence, the *Guidance note* has been created in recognition that a transition from punitive approaches to drug use towards a framework grounded in public health and human rights is necessary if we are to end AIDS as a public health threat. The evidence presented in *Why should drugs be decriminalized as part of the HIV response?* indicates that the decriminalization of drug use and possession for personal use is associated with improved health outcomes, reduced rates of HIV transmission and the promotion of social inclusion.

Recognizing the diverse experiences of countries that have undergone the decriminalization of drug use and possession for personal use, the *Guidance note* aims to compile lessons learned from various national contexts. It recommends that Member States adopt approaches that are responsive to the needs of marginalized communities while ensuring that decriminalization efforts are accompanied by comprehensive support for harm reduction services, treatment and broader social reforms.

The decriminalization of drug use and possession for personal use should foster an enabling environment for people who use drugs to claim and realize their rights in all domains of their lives, including improving HIV outcomes and enabling health providers to better deliver services. Processes and services following decriminalization should promote dignity, choice and build trust within and between communities and public services.

PART 1

1.1 Context, purpose and approach

Context

People who use drugs continue to be disproportionately impacted by the HIV pandemic. **Globally, in 2022, people who inject drugs were 14 times more at risk of contracting HIV than the general adult (15-49) population and 8% of all new HIV infections globally were among people who inject drugs *(1)*.**

In 2024, the median prevalence of HIV among people who inject drugs in reporting countries was 7.1%, ranging from 0% to 53% among the 54 reporting countries *(36)*. Based on available data from 72 countries, less than 2% of people who inject drugs live in countries that report achieving the recommended coverage of sterile needles and syringes and OAMT, such as methadone *(37)*.

In 2021, of the nearly half a million people who died of drug-related causes or drug use, 38.3% (177 279) were due to cirrhosis and other chronic liver diseases, primarily caused by hepatitis C virus (HCV) and 14.6% were due to AIDS related mortality, while 21.5% were due to opioid use disorders *(38)*.

In 2022, WHO reported that approximately 9% of all people who inject drugs acquired HCV that year. A study in 2023 found that almost 40% of people who inject drugs were living with HCV in 2023 *(39, 40)*.

A common feature of drug control efforts has been the adoption of laws and policies that criminalize the possession of drugs for personal use, often framed as a strategy for reducing demand. In practice, this approach has primarily relied on law enforcement measures that have disproportionately impacted people who use drugs and the communities they belong to *(14)*.

Evidence shows that the criminalization and punishment of people who use drugs has had a significant impact on the HIV epidemic, limiting both the provision of and access to health and harm reduction services that protect against acquiring HIV and accessing life-saving treatment *(9)*. Criminalization has been linked to higher HIV prevalence among people who inject drugs, reduced syringe distribution and increased sharing of injecting equipment *(9)*.

In 2019, a systematic review found that repressive policing of drug use within criminalized or punitive settings was associated with higher HIV incidence, higher rates of needle sharing and avoidance of harm reduction programmes *(10)*.

The broader impact of such criminalization has been to undermine key social determinants of health and HIV prevention, including access to stable employment, housing, social inclusion and protection from discrimination. The overly broad application of criminal measures contributes to overcrowding in prisons and other closed settings, where a higher prevalence of HIV and HCV and lower access to prevention and treatment have been documented *(41)*.

Beyond health harms, the broad application of criminal measures is expensive and inefficient: enforcement, prosecution and imprisonment for simple possession absorb substantial public resources *(15)*. Decriminalization reduces justice-system workload and allows funds to be reallocated to evidence-based, highly cost-effective HIV prevention and harm-reduction services *(42)*.

Based on the evidence of the health harms of criminalization, the decriminalization of drug use and possession for personal use is seen as a societal enabler for health, providing a legal environment that has the potential to maximize engagement with HIV testing and treatment services and wider health and social programmes *(13)*. The decriminalization of drug use and possession for personal use, when coupled with support and investment in harm reduction and other social services, can reduce HIV transmission rates *(9, 10, 43, 44)*.

It is for this reason that the Global AIDS Strategy 2021–2026 contains within it a target that by 2025, less than 10% of countries will criminalize the possession of small amounts of drugs.

The need for the decriminalization of drug use and possession for personal use to end AIDS is clear. There are, however, many different approaches to decriminalization. The way in which decriminalization is implemented in law, and the administrative and regulatory regimes that surround the laws, as well as the implementation in practice, can have differing impacts on HIV outcomes for the communities in question. It is important to learn lessons from the different approaches taken by governments that have removed harmful criminal laws to understand what is working and what can be improved.

Purpose and audience

UNAIDS, UNDP and INPUD, in collaboration and consultation with other UN agencies, organizations led by people who use drugs and other experts in the field of HIV, human rights, and drug policy, have developed the *Guidance note* to support countries to develop effective, public health and rights-based models of the decriminalization of drug use and possession for personal use in the context of HIV.

The *Guidance note* presents experiences and learnings from jurisdictions that have decriminalized drugs. While there is no best practice in any one jurisdiction, by highlighting promising practices in approaches to the decriminalization of drug use and possession for personal use and examining the advantages and disadvantages in relation to HIV outcomes, the aim is to provide understanding and knowledge of how to more effectively legislate to support the right to health in the context of the HIV response.

The stakeholders who are or should be involved in the decriminalization of drug use and possession for personal use efforts are many, including parliamentarians, people who use drugs, various ministries, including health, youth, justice, law enforcement, gender, social protection and others, as well as civil society organizations, medical professionals and academic experts.

The *Guidance note* is intended as a resource for all persons involved in advocacy towards, as well as design and implementation of, the decriminalization of drug use and possession for personal use in the context of HIV.

Part 1 of the G*uidance note* aims to give an overview of the topic of the decriminalization of drug use and possession for personal use, including what it is, where it has been implemented, and how criminal law affects HIV outcomes. It discusses how decriminalization should be implemented to be most effective in supporting the HIV response.

Part 2 examines various aspects of decriminalization models, including determining whether possession is for personal use, the role of law enforcement and courts, and State responses to drug use, such as sanctions. It explores the impact of these models on HIV outcomes from a public health and human rights perspective, including their effect on the availability, accessibility, acceptability and quality of health services. It seeks to provide lessons that can be learned from these approaches to ensure a rights-based approach to the decriminalization of drug use and possession for personal use is advocated for and achieved.

Scope

This document covers the decriminalization of drug use and possession for personal use as it relates to the HIV response and HIV outcomes. It focuses on the laws themselves, including defining what acts are decriminalized and what remain within the criminal law system, as well as the role of the criminal justice system, including law enforcement and the judiciary. It covers not only the decriminalization of drug use, but also drug possession and the possession of drug-related paraphernalia, such as equipment used for the consumption of drugs, as well as a discussion on public drug use.

While there is a difference between HIV transmission risk associated with injecting and non-injecting drug use the HIV epidemic cannot be viewed purely through the lens of injecting drug use. Doing so would overlook that non-injecting drug use, such as sexualized drug use including chemsex, can still lead to HIV transmission, particularly where harm reduction equipment, such as safe pipes for drug inhalation, are not available, and would overlook that people using different routes of administration are not distinct populations: people consuming drugs via non-injecting methods may have injected in the past and may use different methods of administration simultaneously because of polydrug use.

Moreover, viewing the issue only through the lens of injecting drug use would fail to recognize the ways in which criminalization of *all* people who use drugs has a negative impact on the HIV epidemic, insofar as it prevents an enabling environment for people to realize their right to health.

As such, the Guidance note is relevant for all narcotic and psychotropic substances under the 1961 Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. Throughout the *Guidance note*, unless the data or

source material is specific only to people who inject drugs, we refer not just to 'people who inject drugs' but all people who use drugs.

While not the focus of the *Guidance note*, it also briefly covers the broader elements that are required in addition to decriminalization to support an effective HIV response, including addressing underlying determinants of health, such as housing and social services as well as the need for harm reduction services, broader health services, reductions in stigma and discrimination and strong community leadership.

Methodology

To produce the *Guidance note*, a range of methods were used, including legal and policy reviews, surveys distributed to country and regional offices and community and expert consultations. These consultations were led by INPUD and provided in-depth insight from the community of people who use drugs, civil society groups, UN country teams and an international advisory community of drug policy experts. Their expertise, and crucially the expertise of people with lived and living experience, was essential for an accurate reflection on the lives of people who use drugs and the effects of drug policy. All information provided has been anonymized to ensure confidentiality. Further information on methodology is provided in Annex 1.

1.2 What is meant by 'decriminalization of drugs in the context of HIV'?

The *Guidance note* speaks about the decriminalization of drugs in the context of HIV.

Decriminalization is a process, the end result of which is that a particular act is no longer a criminal offence (for example, by removal from the criminal code) and all criminal penalties are removed. In decriminalization models relating to drug use, typically this is the removal of personal drug use and other minor drug offences from the criminal code.

It is distinct from depenalization, where an act remains criminal, but the custodial sentences are removed. In cases of decriminalization, there may be no penalty at all, or in some cases, a small penalty such as a small fine, but no criminal record *(15, 29, 30)*.

Decriminalization does not mean legalization. Legalization, sometimes referred to as a regulated market, refers to legal frameworks that explicitly permit an activity, whereby activities *within* the parameters of that framework are legal. Drug use decriminalization models, as they are meant here, do not regulate the whole drug supply chain or create any such regulatory framework. The cultivation, trafficking and supply of drugs for commercial gain remain criminal in most cases.

Some jurisdictions that have decriminalized drug use and possession have also decriminalized activities beyond possession and use; for example, cultivation of a plant (most often cannabis, although Bolivia has decriminalized the cultivation of the coca leaf for traditional uses, and Thailand has decriminalized kratom cultivation) and/or supply where there is no financial gain.

As outlined elsewhere in the *Guidance note*, there are a number of activities relating to drug use that, when criminalized, have a negative impact on the HIV response. These include drug use and possession for personal use and the possession of drug paraphernalia such as needles and syringes or, in some cases, the provision of information in relation to harm reduction.

In the *Guidance note*, when we refer to the decriminalization of drug use and possession for personal use it is always in the context of the HIV response. However, when decriminalizing use and possession of drugs for personal use, a number of other elements need to be decriminalized to give effect to these changes. As such, 'decriminalization of drug use and possession for personal use' should be understood as referring to:

1. **Decriminalization of drug use and possession for personal use.**
2. **Decriminalization of the provision, purchase and possession of drug paraphernalia, such as needles and syringes.**
3. **Decriminalization of the provision of information in relation to safe consumption of drugs.**

Decriminalization usually describes a policy shift that is achieved through legislative reform or a decision of a constitutional court or other apex judicial institution. This is known as de jure decriminalization. Decriminalization is also occasionally used to refer to situations where the relevant criminal laws remain in place, but there is an explicit policy of non-enforcement, known as de facto decriminalization or depenalization *(29)*. Unless otherwise indicated, we are discussing de jure decriminalization in the *Guidance note*.

When criminal offences and penalties are removed, in some cases decriminalization models may replace these with administrative penalties, such as fines or other consequences (e.g. referral to health treatment).

As will be discussed, these can sometimes have similar negative consequences to criminal sanctions, for example, where fines are too high or treatment is not voluntary. These are included in the *Guidance note* as part of an overall approach to decriminalization to ensure that what is put in place does not recreate the barriers to a successful HIV response, as required by the 2021 Political Declaration on HIV/AIDS and the Global AIDS Strategy.

Key terms and definitions

De jure decriminalization of drug use and possession for personal use refers to models that have removed criminal penalties for use and possession of drugs (and possibly other drug-related activities) within the law. This includes both models that have been developed through legislation or those that have been developed through court decisions.

In some models of decriminalization, other kinds of penalties, for example administrative penalties, may remain or be added, in other models no punitive measures apply to the consumption and possession of drugs for personal use.

De facto decriminalization (or depenalization) refers to models where the criminal law is retained, so use and/or possession are still technically a criminal offence, but the law is not enforced.

Administrative or civil penalties refer to punishments that do not result in a criminal conviction or record but can be given by police, courts or administrative bodies. Examples include fines, confiscation of documents (such as passports), and referral to treatment or education interventions. These types of penalties do not lead to a criminal record.

Criminal penalties refers to punishments that can be given by police or courts and result in a criminal record. Examples include criminal fines, community service, imprisonment, as well as where it is considered a criminal offence and recorded as such, mandatory referral to treatment or education interventions. These are associated with people getting criminal records, which could potentially further aggravate their situation, including through increased stigma and discrimination.

1.3 Foundational principles for the decriminalization of drug use and possession for personal use in the context of HIV

The decriminalization of drug use and possession for personal use should foster an enabling environment for people who use drugs to claim and realize their rights in all domains of their life, including improving HIV outcomes.

Processes and services following the decriminalization of drug use and possession for personal use should promote dignity, choice, and build trust within and between communities and public services. Based on testimony from community members, country experience, human rights principles and international evidence, foundational principles have been identified to guide stakeholders as they initiate and/or move through the process of decriminalization.

1. **A human rights-based approach.** Including but not limited to the right to participation and the right to health, ensuring the availability, accessibility, acceptability and quality of health services to all without discrimination.

2. **A public health approach including an enabling legal environment for the HIV response, with reduced law enforcement contacts and removal of sanctions.** The decriminalization of drug use and possession for personal use should aim to remove all barriers to health services and support the HIV response. Non-criminal responses to drug use should not recreate the harms or barriers of criminal laws. **Options such as a no-sanctions approach appear to have the best impact in terms of an enabling environment for the HIV response**. As the harms of criminalization stem not only from experiences of arrest and incarceration but also from unnecessary interactions with police, the minimization of contact with law enforcement, as well as with the criminal justice system generally, should be prioritized. Where contact with law enforcement is inevitable, a human rights-based approach to policing that supports public health outcomes should be applied.[2]

3. **Bodily autonomy, voluntary informed consent and removal of coercive practices.** Coercion is built into many health and justice systems to address drug use despite the lack of evidence that they provide any benefit to individuals and the enormous evidence that demonstrates the violence and harm they can cause. Targeted and concrete steps to ending coercive practices in the care and support of people who use drugs, replaced by voluntary well-resourced social and health services, ensures sustainable, humane and evidence-based progress in any decriminalization process.[3]

2 International Guidelines on Human Rights and Drug Policy. Guideline II.7.iv-vii, Freedom from arbitrary arrest and detention; Guideline III.1.2.v, Interventions for children who use drugs; Guideline III.2.iv, Women, drug-related offences, and dependence on illicit economies.;

3 Guideline II.1.1, harm reduction; Guideline II.1.2, Drug dependence treatment; Guideline II.7, Freedom from arbitrary arrest or detention; Guideline III.1.2, Interventions for children who use drugs; Guideline III.2.1, Interventions for women who use drugs; Guideline III.3.iii, Persons deprived of their liberty.;

4. **Non-discrimination.** Decriminalization policies must be equitable and non-discriminatory. Ongoing monitoring is crucial to prevent unintended negative impacts on marginalized communities, particularly people living with or affected by HIV, including other key populations.[4]

5. **Meaningful participation.** People who use drugs, including those from different communities and representing intersecting experiences, must be actively involved in the design, development and implementation of public policies related to the decriminalization of drug use and possession for personal use and other drug law reforms.[5]

6. **Transparent and accountable systems.** Decriminalization should reflect good governance principles. Accessible information regarding proposed decriminalization reforms is a cornerstone of transparency. How decisions around decriminalization are made, who is included in the process and how these processes can be scrutinized and public bodies held accountable are equally fundamental. Governments should ensure constructive forms of accountability that enable ongoing monitoring, review and remedial action to strengthen human rights and public health outcomes throughout the processes of decriminalization as well as once reforms are implemented. Adaptability is a key component of remedial action particularly as drug consumption patterns and drug markets change.[6]

7. **Decriminalization of the use and possession for personal use of all drugs.** To meet the goals of the Global AIDS Strategy, decriminalization of drug use and possession for personal use must include all drugs that were previously criminalized.

8. **Decriminalization as part of a broader health and rights approach including:**

    a. **Addressing multiple and intersecting forms of stigma and discrimination** that exclude people who use drugs from many aspects of ordinary social and family life, trapping them in cycles of social, economic and political marginalization.[7]

    b. **Addressing underlying determinants of health** for people who use drugs, which may include reforms that enable access to work, social protection, housing, family support and educational opportunities.[8]

    c. **Provide harm reduction services and evidence-based treatment** that is available, accessible, acceptable and of good quality. These systems and services may take time to build. Their absence

4 Guideline I.3, Equality and non-discrimination; Guideline IV.1, Data collection.

5 Guideline I.4, Meaningful participation.

6 Guideline I.5, Accountability and the right to an effective remedy; Guideline IV.2, Human rights review and budget analysis.;

7 Guideline I.3, Equality and Non-Discrimination.

8 Guideline II.1, Right to health.

or current weakness should not preclude decriminalization from happening now.[9]

1.4 International law, UN policies and standards relating to the decriminalization of drug use and possession for personal use

1.4.1 UN treaties, conventions and resolutions

As mentioned above, the principal resolution relating to the HIV response is the five-yearly UNGA Political Declaration on HIV/AIDS. In the most recent resolution in 2021, States expressed concern at the restrictive and discriminatory laws and practices that target people living with, at risk of and affected by HIV, and committed to,

> "Creating an enabling legal environment by reviewing and reforming, as needed, restrictive legal and policy frameworks, including discriminatory laws and practices that create barriers or reinforce stigma and discrimination such as age of consent laws and laws related to HIV non-disclosure, exposure and transmission … with the aim of ensuring that less than 10 per cent of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025." *(12)*

In terms of drug policy, the three UN drug conventions[10] are the framework for the international approach to drug policy, with State parties to the conventions required to implement the control measures contained within the conventions. While the conventions are the main framework for dealing with controlled substances, they exist alongside human rights treaties and must be interpreted in line with human rights obligations outlined below.

The UN drug conventions commit to "… the health and welfare of mankind". Article 36 of the Single Convention of Narcotic Drugs 1961 allows for alternatives to punishment for possession of drugs and also provides flexibility for States where Article 36 would contravene constitutional obligations or a country's legal norms *(45)*. This approach is also reflected in the 1971 and 1988 conventions. The 1988 convention, for example, established criminal liability for "possession, purchase or cultivation of drugs for personal consumption" but, like the 1961 and 1971 conventions, is subject to the constitutional limitations of a State Party and to the constitutional principles and basic concepts of [the State Party's] legal system *(46, 47)*.

9 Guideline II.1, Right to health; Guideline II.3, Right to an adequate standard of living; Guideline II.4, Right to social security.

10 The Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol; the Convention on Psychotropic Substances of 1971; and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

As noted by UNODC, the conventions do not require States to establish drug use or possession for personal use as a criminal offence per se *(15)*. The *International Guidelines* also make clear that the conventions "contain sufficient flexibility to decriminalize possession of drugs for personal use" *(28)*.

As the International Narcotics Control Board (INCB) has stated,

> "States have an obligation under the drug control conventions to establish certain behaviours as punishable offences and to ensure that serious offences are liable to adequate punishment, particularly by imprisonment; however, that obligation is subject to the constitutional principles of the State and to the principle of proportionality. For minor drug-related offences, including possession of small quantities of drugs for personal use committed by people who abuse drugs, the conventions do not oblige States to adopt punitive responses" *(48)*.

Indeed, as outlined in UNODC's 2025 World Drug Report,

> "As noted by the INCB, disproportionate responses to drug-related offences can undermine the overall principles of the international drug conventions, the rule of law, and the enjoyment of the right to health. Recognizing drug use and drug use disorders as a public health concern that require responses that are health-centred and less reliant on punitive sanctions is entirely consistent with what is foreseen in the international drug control framework" *(14)*.

As outlined in the *Guidance note*, when optimally implemented, the decriminalization of drug use and possession for personal use—where it is non-discriminatory, involves no punishment, little to no contact with law enforcement, and ensures access to health and social services—can aid States in upholding their international human rights obligations *(24)*. As such, the international human rights system has made a range of authoritative recommendations through various UN human rights mechanisms and OHCHR, such as repeated calls for the decriminalization of drug use and possession for personal use.

In addition to the bodies mentioned above, other Member State-led entities—including the UNGA, the Human Rights Council (UNHRC) and the UNAIDS Programme Coordinating Board (PCB)—have adopted resolutions and made specific commitments supporting drug policy and criminal law reforms aligned with human rights and public health objectives.

In 2016, the UNGA held a special session on drugs. The outcome document for this session called for the,

> "… development, adoption and implementation, with due regard for national, constitutional, legal and administrative systems, of alternative or additional measures with regard to conviction or punishment in cases of an appropriate nature …" *(49)*

In 2024, the UNGA encouraged,

> "Member States to consider **alternative, non-custodial measures for persons accused of minor, non-violent drug-related offences,** to promote, consistent with the three international drug control conventions and domestic law, and in accordance with national, constitutional, legal and administrative systems, alternative or additional measures with regard to conviction or punishment in cases of an appropriate nature, and to ensure that law enforcement drug control efforts are both consistent with States' commitments to effectively addressing and countering the world drug problem as well as their human rights obligations." *(50)*

The PCB has requested that Member States address harmful and punitive laws affecting the HIV response for key populations and requested that UNAIDS supports Member States in addressing structural barriers to HIV services, such as criminalization *(51, 52)*.

1.4.2 International human rights law and the International Guidelines on Human Rights and Drug Policy

As mentioned above, the international drug conventions are subject to international human rights obligations and must be interpreted and implemented in line with those obligations. Human rights treaty bodies, as well as UNHRC special procedures, have made numerous recommendations, both generally and to specific countries, to decriminalize drug use as part of their obligations under human rights law and particularly in relation to the right to health *(16,20)*.

In 2024, the UNHRC resolution on human rights in the context of HIV/AIDS, adopted by consensus, called for Member States "… to review or repeal those restrictive, punitive or discriminatory legal and policy frameworks that adversely affect the successful, effective and equitable delivery of, and access to, HIV prevention, diagnosis, treatment, care and support programmes and services for all persons living with, presumed to be living with, at risk of or affected by HIV, including key populations." *(53)*

In 2023, it also adopted a resolution on the contribution of the Human Rights Council with regard to the human rights implications of drug policy, in which it called upon Member States to consider alternatives to incarceration, conviction, and punishment *(54)*.

The resulting report of the 2023 resolution states that "together, the social, political, commercial, and legal determinants of health influence environments in which a person may produce, distribute, or use drugs and can create and reinforce health disparities. An alternative, evidence-based and public health- and human rights-centred approach to drug use is urgently needed." *(18)*

In 2019, UNHRC adopted a resolution that encouraged all Member States, "To consider reviewing laws and practices that may give rise to arbitrary detention in accordance with the recommendations of the Working Group [on Arbitrary Detention]." *(55)*

The report by the Working Group on Arbitrary Detention, requested by this UNHRC resolution, recommended, among others, "Decriminalize the use, possession, acquisition or cultivation of drugs for personal use, including the possession of associated drug paraphernalia." *(56)*

International human rights law, in addition to recommending that drugs be decriminalized as a key step in meeting human rights obligations, also provides a strong framework and recommendations to guide the implementation of decriminalization. The right to health, for example, includes within it the obligation to ensure the availability, accessibility, acceptability and quality of health services, which includes both HIV and harm reduction services *(57)*. Such a framework provides a basis for analysing whether different models of decriminalization will support or undermine the right to health, including in relation to HIV. This is further explored elsewhere in the *Guidance note*.

Launched in 2019, the *International Guidelines on Human Rights and Drug Policy* (*International Guidelines*), developed through series of global expert and community consultations and by OHCHR, UNAIDS, UNDP, WHO and the International Centre on Human Rights and Drug Policy at the University of Essex, recommend applying existing international human rights law to drug control to maximize human rights protections *(28)*.

The *International Guidelines* provide an essential normative bridge between international drug control and human rights law, offering a coherent framework for interpreting and applying international legal obligations in ways that uphold the dignity, health and well-being of individuals and communities.

The *International Guidelines* serve as a reference tool for those working to ensure human rights compliance at local, national and international levels, including those seeking to advance the decriminalization of drug use and possession for personal use as a step towards strengthening the human rights environment for their communities. The *International Guidelines* have been noted by UNHRC *(54)* and referenced by a number of UN human rights treaty bodies in concluding observations, calling on State Parties to utilize the guidelines in developing drug policies *(58)*.

In relation to the right to health, the *International Guidelines* note that States may,

> "Utilise the available flexibilities in the UN drug control conventions to decriminalise the possession, purchase, or cultivation of controlled substances for personal consumption." *(28)*

In a similar vein, the International Commission of Jurists has developed a set of legal principles to address the harmful human rights impact of unjustified criminalization of individuals and entire communities. The principles are based on existing legal principles and international human rights law and clearly state that, "Criminal law may not proscribe: a) drug use or the possession, purchase or cultivation of drugs for personal use, including by anyone under the age of 18 or while pregnant …" *(59)*

1.4.3 UN agency commitments, norms, standards and recommendations in relation to the decriminalization of drug use and possession for personal use

In 2018, at the UN Chief Executives Board, the heads of 31 UN agencies adopted a common position on drug policy (UN System Common Position), which committed agencies to support governments "to promote alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use." *(21)* This was the first time a joint UN position had been adopted in relation to drug use.

The UN System Common Position contains multiple commitments relevant to drug use and possession for personal use, including explicit support for decriminalization in its commitment, "… and the review of laws that may contribute to or exacerbate stigma, discrimination, marginalization of violence, including those relating to drug use. It calls for a rebalancing of approaches towards public health, including prioritizing "alternatives to incarceration, including treatment, rehabilitation and social integration." *(21)*

Other UN agencies have made recommendations and commitments relating to decriminalization prior to and after this occasion.

UNAIDS Global AIDS strategies have called for the repeal of laws targeting people who have used drugs since at least 2011, with the 2021 strategy including a specific target on this issue *(13, 60)*.

Recognizing the importance of an enabling legal environment, including decriminalization of drug use, in ending AIDS as a public health threat, the Global AIDS Strategy 2021–2026 includes specific targets related to criminal and punitive laws—namely, that by 2025, less than 10% of countries will criminalize same-sex sexual activity, the possession of small amounts of drugs, sex work or HIV exposure, non-disclosure and transmission *(13)*.

In 2007, a joint technical paper by UNAIDS, WHO and UNODC on treatment in prisons recommended that States strengthen the principle of education and treatment provision as alternatives to conviction and punishment *(61)*.

WHO, in its *2022 Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations*, included a recommendation for countries to review punitive laws and work towards the decriminalization of drug use and possession for personal use as an intervention that is essential for impact *(26)*.

The WHO HIV guidelines cited research and modelling that showed that criminalization has "measurable, detrimental effects on the health of members of key populations", stating that "Without protective policies and decriminalization of drug use or possession, and of diverse forms of gender identity and sexuality and sex work, barriers to essential health services will remain; many people from key populations may fear that seeking health care will expose them to adverse legal consequences … shown by modelling and other research." *(26)*

The WHO HIV guidelines also recommend decriminalization of drug paraphernalia such as needles and syringes *(26)*.

UNAIDS has consistently called for the decriminalization of drug use and possession for personal use as a key element in the HIV response. In 2015, in its report *Do no harm: health, human rights and people who use drugs*, UNAIDS laid out five policy recommendations, including,

> "Commit to treating people who use drugs with support and care, rather than punishment. UNAIDS believes that this objective can be achieved only by implementing alternatives to criminalization, such as decriminalization and stopping incarceration of people for the consumption and possession of drugs for personal use." *(62)*

In 2016, several UN agencies, including UNAIDS, WHO, UNDP and UNFPA alongside INPUD, developed a tool for implementing HIV programmes for people who use drugs, Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs, a practical guidance for collaborative interventions which again reaffirmed the need to decriminalize the use of drugs as well as the possession of drug paraphernalia such as needles and syringes *(27)*.

In 2017, eleven UN agencies issued a joint statement on ending discrimination in healthcare. The statement committed agencies to "supporting States to put in place guarantees against discrimination in law, policies and regulations by … reviewing and repealing punitive laws that have been proven to have negative health outcomes and that counter established public health evidence. These include laws that criminalize or otherwise prohibit … drug use or possession of drugs for personal use." *(63)*

In line with its mandate to promote and protect human rights, OHCHR has consistently recommended that States consider alternatives to incarceration and the decriminalization of drug use and possession for personal consumption, particularly for minor, non-violent drug-related offences.

OHCHR has highlighted that criminalization and punitive approaches often exacerbate health risks, contribute to prison overcrowding and undermine the right to health by deterring individuals from seeking treatment and harm reduction services. Instead, OHCHR encourages the adoption of evidence-based, voluntary treatment, rehabilitation and social integration measures as more effective and humane responses *(22–24)*.

In line with its mandates, UNODC fosters intergovernmental dialogue on the topic through the provision of evidence-based research on the implementation of various decriminalization approaches, as published through its World Drug Reports.

The 2025 World Drug Report noted that the criminalization of drug use and resulting incarceration of people who use drugs or have drug use disorders have high costs, both direct and indirect, for individuals, their families and the community, as well as placing a significant financial burden on State resources.

> "Disproportionate responses can actually undermine the principles of the international drug conventions and the right to health, and that policies that treat drug use as a health concern are consistent with the international drug control framework, noting also that policies targeting people who use drugs can add to stigma and discrimination." *(14)*

1.4.3 Community calls for the decriminalization of drug use and possession for personal use

People who use drugs have been advocating for the decriminalization of drug use and possession for personal use as an essential element in ending AIDS and realizing their right to the highest attainable standard of health since the early days of the HIV epidemic *(64, 65)*.

The Vancouver Declaration of 2006, which led to the creation of INPUD, specifically addresses the need to change national legislation and ensure people who use drugs are not incarcerated *(66)*. With INPUD officially launching on 1st November 2008, the first day of November has since been marked as International Drug Users Day. INPUD's consensus statement on Drug Use Under Prohibition, released in 2015, stresses the harmful impact of criminalization on health and sets out the fundamental demands to promote and protect the human rights, wellbeing and dignity of all people who use drugs:

> "Since people who use drugs are frequently criminalised, drug-using paraphernalia, such as syringes and needles, can be used as evidence of drug use by the police, and paraphernalia can be confiscated and/or destroyed by police. This impedes safer, hygienic use of drugs and serves as a disincentive for people who use drugs to carry sterile injection paraphernalia. This increases the likelihood of rushed injecting and needle sharing, increasing the risk of overdose and impeding efforts to prevent transmission of blood-borne infections like HIV and hepatitis C. People who use drugs in public spaces fear state-sponsored harassment, violence, and arrest, and again this results in rushed drug use, and people using drugs in unhygienic and dangerous conditions." *(67)*

In addition to the work of INPUD, the *Support. Don't Punish.* campaign was established in 2013, supported by global, regional and grassroots communities and civil society organizations calling for drug policies that prioritize public health and human rights over punitive approaches to drugs *(68)*.

The International Drug Policy Consortium, which consists of 198 member organizations focused on drug policy, including organizations led by people who use drugs, developed a gold standard of drug decriminalisation, noting that criminalization worsens public health and welfare outcomes such as HIV and hepatitis infections and drug-related deaths. The gold standard calls for, "the removal of all sanctions for drug use and related activities including possession, acquisition, purchase, cultivation and possession of drug use paraphernalia." *(69)*

WHO, in revising the *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations*, undertook qualitative studies on the values and preferences of key populations, led by the global key population networks: INPUD, the Global Network of Sex Work Projects, Global Action for Trans Equality and MPact Global Action for Gay Men's Health and Rights. The researched aimed to understand the lived experience, values and preferences and other non-biomedical interventions that work for key populations. The most recent version of the guidelines on HIV and key populations reported that this research found,

> "The criminalization of drug use or possession, sex work, same-sex relations and gender expression deter members of key populations from accessing services due to fears of legal repercussions. It was also noted how criminalization perpetuates the exclusion of key population-led and rights-based health programming from funding mechanisms and state health responses. Participants in the qualitative study additionally noted that law enforcement using the possession of condoms and injecting equipment as so-called evidence of sex work and drug use or possession further hinders the use of evidence-based prevention services and commodities." (26)

1.5 Why should drugs be decriminalized as part of the HIV response?

UNAIDS, UNDP, INPUD, other UN agencies, communities and other experts have long recognized that legal environments play a key role in the HIV response and can either enable or undermine HIV programmes and outcomes *(14, 24, 25, 70, 71)*.

There has been increasing attention to the ways in which criminalization of drug use and possession for personal use and related law enforcement practices, undermine the promotion and protection of a range of civil, political, economic, social and cultural rights, particularly for people living with and affected by HIV, including key populations *(13, 25, 63, 72-74)*.

Health impacts

People who inject drugs are disproportionately impacted by the HIV epidemic and by other blood-borne viruses such as hepatitis. In 2021, of the nearly half a million people who died of drug-related causes or drug use, 38.3% were due to cirrhosis and other chronic liver diseases, primarily caused by HCV and 14.6% were due to AIDS related mortality *(14)*.

Reported median prevalence of HIV among people who use drugs in 2024 was 7.1% (54 reporting countries), ten times that of the rest of the adult (15–49) population. In the 20 countries with disaggregated data, HIV prevalence among women is 14.5%, compared to 8.6% of men, among people who inject drugs *(36)*.

In 2022, WHO reported that approximately 9% of all people who use drugs acquired HCV that year and a 2023 analysis found that almost 40% of people who inject drugs were living with HCV *(39, 40)*.[11]

Punitive drug control laws, policies and law enforcement practices have been shown to be among the largest obstacles to health care in many countries, along with a lack of political will and financing for harm reduction services. Criminalization has been found to deter people from accessing harm reduction services or carrying and using harm reduction equipment, increasing stigma and discrimination, and creating a climate of fear among health care and harm reduction providers. The threat of punishment deters people from coming forward to seek help for treatment, seeking help when they require emergency assistance or accessing services and tools to help them to practice protective behaviours (14, 9, 10, 75, 76). Undermining access to dignified services not only impacts health outcomes, it also contravenes core right to health obligations.

Systematic reviews in 2017 and 2019 showed criminalization to have a negative effect on HIV prevention and treatment, finding it to be associated with higher

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rates of needle sharing, lower engagement with needle–syringe programmes and higher HIV incidence and prevalence *(9, 10)*.

Street-level policing of minor drug offences through relocation or arrest/incarceration was found to displace people who use drugs from areas served by harm reduction programmes, undermining access to sterile syringes, OAMT and outreach workers *(10)*.

According to UNODC, in 2023 6.1 million people were in formal contact with the policy for drug-related offences. Of those 6.1 million, 4 million (66%) were for drug possession/use. Some 1.6 million people were prosecuted for drug possession/use and of those, 850,000 were convicted (compared to 490,000 for drug trafficking) *(14)*.

Women who use drugs are more likely than their male peers to be living with HIV, face higher rates of conviction and incarceration if arrested, face particular challenges in accessing harm reduction services tailored to their needs and experience higher levels of stigma and discrimination *(14)*.

A joint statement of experts following a UNODC scientific consultation in 2014 declared, "an urgent need to realign harm reduction and law enforcement approaches to support prevention and treatment of HIV and HCV among people who inject drugs *(77)*. The Johns Hopkins–Lancet Commission on Drug Policy and Health has specifically called for the decriminalization of use, possession and petty sale of drugs and the strengthening of health and social-sector alternatives to criminal sanctions *(78)*.

The clear links between criminalization and negative health outcomes has led UNAIDS, UNODC, WHO, OHCHR, INPUD, the International Drug Policy Consortium, the Global Commission on Drug Policy and the Global Commission on HIV and the Law to recommend the decriminalization of drug use as a key element in the HIV response *(14, 15, 24-26, 69-71, 74, 79)*.

Prison overcrowding

As noted above, in 2023, 1.4 million people were convicted of a drug-related criminal offence, 61% of those convictions (850 000 people) were for drug possession and/or use *(14)*.

Criminalization of drugs results in population increases in prisons and other closed settings, such as compulsory drug detention and rehabilitation centres, leading to overcrowding and related health risks *(15, 80)*.

As noted by UNODC, incarceration resulting from such policies has severe negative consequences for people with drug use disorders, their families, and their communities that can worsen the underlying health and social conditions and the overall impact on health *(14)*.

A study in 17 European countries conducted between 2006 and 2020 showed that, among people who inject drugs who were recruited from the community, a history of incarceration was associated with a positive HIV and HCV serostatus *(81)*.

Social determinants of health

Social determinants of health describe the factors that can influence health outcomes. Examples include economic stability, education, social and environmental context, access to housing and healthcare, social inclusion and non-discrimination and experiences of racial disparities and other forms of marginalization *(82)*.

Criminalization of drug use and drug possession can directly and negatively undermine broader social determinants of health, hindering access to employment and education, leading to loss of housing, and creating issues with child custody and immigration. These experiences can directly affect the lives of people living with HIV, undermining access to HIV prevention, treatment and care and increasing the risk of acquiring HIV, while also limiting their ability to create healthy environments to manage that care *(83, 84)*.

Further, the overrepresentation of people of colour and those with mental health problems has prompted research into the role of policing and criminalization as a social determinant in its own right. Commentators have noted that,"criminal legal involvement, whether related to actual criminal behaviour or not, can interfere with mental health, increase risk for mental illnesses and substance use disorders and worsen the course of illness or outcomes among those with existing mental illnesses." *(85)* Researchers have called on mental health professionals, "to appreciate the relationship between criminal legal contact and systemic racism", recognizing that such contact, which undermines health, "may be precipitated by implicit bias, policing practices and discriminatory laws." *(85)*

Benefits of decriminalization as part of broader reforms and services

The decriminalization of drug use and possession for personal use is associated with improved health outcomes, reduced overdoses, reductions in prison populations and improved access to harm reduction and treatment services *(44, 79)*. Further, decriminalization reduces the burden on the criminal justice system and can represent reduced financial costs to the State, both directly and indirectly *(42, 44, 79)*.

When comparing the experiences of people who have been criminalized to those who have been subject to a decriminalized framework, negative outcomes have been documented in terms of denial or loss of employment *(86)*. Research has also found improved outcomes for those who have been subject to non-criminal justice processes in terms of housing security and on family relationships *(86)*.

The decriminalization of drug use and possession for personal use must be part of a broader set of interventions and programmes. Drug law reform is a critical driver, but not the only driver, of the positive outcomes listed below.

Many countries and regions, such as Canada (British Columbia), Czechia, the Netherlands, Portugal, Switzerland and Uruguay, have paired decriminalization reforms with investments in harm reduction, treatment and other health and social services.

The decriminalization of drug use and possession for personal use is a work in progress and there is no perfect example; thus, the benefits that decriminalization can potentially bring can be undermined in the countries where it exists. Where, for example, a decriminalization model is discriminatory against people who have a drug dependence by improperly defining amounts for personal use, this excludes the communities most likely to benefit from decriminalization and naturally limits how far the decriminalization framework can lead to societal benefit.

1.6 The decriminalization of drug use and possession for personal use: progress so far

In 2021, the Global AIDS Strategy set a target that by 2025, less than 10% of countries would criminalize possession of small amounts of drugs.

Twenty-nine countries do not criminalize possession of small amounts of drugs, and civil society reports up to 39 countries adopting decriminalization models *(32, 87)*. This group of 39 countries spans all continents, with South Africa becoming the first African state to decriminalize non-medical adult use of cannabis through a combination of a 2018 Constitutional Court decision and subsequent legislation (the Cannabis for Private Purposes Act 2024). Some countries, such as Spain and Italy, have had decriminalization models in place since the 1980s and early 1990s *(88, 89)*.

Some of the existing models include a range of drugs, while others will only decriminalize a specific substance. Portugal ended criminal sanctions for possession of all drugs, recently adding synthetic opioids to the list of substances that are decriminalized *(90, 91)*. In British Columbia, only four types of substances are decriminalized: methamphetamines, cocaine, MDMA and opioids *(92)*.

As explained in Part 2 below, in addition to what drug is decriminalized, countries vary as to how personal use is determined. Many use threshold quantities (TQs), where the law allows for possession of a certain quantity of drugs before there is suspicion of trafficking or selling, while others may have no limits and require additional evidence of criminal behaviour (e.g., evidence of selling for profit).

Countries also differ in the types of alternative approaches to criminal penalties. Some may have administrative penalties such as heavy fines, while others require individuals to go through drug courts—though these are still technically part of the criminal justice system—or undergo compulsory treatment. Others simply refer individuals to health centres or have no consequences at all. Depending on the approach, these consequences may have similar HIV impacts to criminal penalties, particularly where there may be heavy fines, police engagement or compulsory treatment.

These are some of the reasons why the 'how' of decriminalization is so important for the HIV response. The most successful models will be those that are developed with a view to realize the rights of people who use drugs and end their criminalization. Crucially, effective decriminalization of drug use and possession for personal use will have the greatest potential to reduce HIV transmission, increase engagement with HIV services as well as harm reduction and drug treatment programmes and will positively impact other public health outcomes, resulting in societal benefits, such as reduced incarceration and reduced public expenditure.

1.7 A framework for implementing decriminalization of drug use and possession for personal use to support the HIV response

While Part 2 will go into the specifics of issues such as sanctions, determination of offences and the role of law enforcement, the following section provides a public health and human rights framework on how to approach and implement decriminalization of drug use and possession for personal use in the context of HIV.

1.7.1 A rights-based approach

It is only through a human rights-based approach that an effective public health response will be achieved. A critical outcome for any process of decriminalization should be to foster an enabling environment for people who use drugs to claim and realize their rights in all domains of their lives.

This means embedding a human rights-based approach into both the process and outcomes of decriminalization, including but not limited to building public safety responses and health services that work for all people, including people who use drugs. Processes and services should be established that promote dignity, choice and build trust within and between communities and public services *(35, 93)*. This includes:

- **Right to health.** Ensuring that approaches to the decriminalization of drug use and possession for personal use support the realization of the right to health, including:

    a. **Ensuring the availability, accessibility, acceptability and quality** of essential health services and medicines, including HIV, harm reduction and other health services, without discrimination.

    b. **Ensuring confidentiality and privacy.**

    c. **Freedom from forced or coerced medical treatment** including preventative or diagnostic interventions such as forced drug treatment *(28, 57)*. The use of coercive or mandatory treatment as a punishment is a breach of the right to health and is contrary to States' obligations that informed consent is a precondition for treatment and that engagement is voluntary *(28, 57, 95)*. This type of treatment can

in some circumstances amount to torture and other cruel, inhuman or degrading treatment or punishment that are absolutely prohibited in international law.

d. **Addressing the social determinants of health** including housing, adequate standard of living and social protection.

- **Indivisibility and interrelation with other rights.** Identification of, and action to realize, other rights that interrelate with the right to health and HIV outcomes, including freedom from torture, bodily autonomy, privacy, right to a fair trial, as well as to adequate housing, education and employment, all of which can be impacted by approaches to (the decriminalization of drug use and possession for personal use *(28, 57)*.
- **Participation.** Meaningful engagement of people who use drugs has a vital role to play in the design, development and implementation of public policy. This must include reform processes related to decriminalization *(24, 28)*.
- **Non-discrimination.** Approaches to the decriminalization of drug use and possession for personal use should not discriminate, in law or in practice and the benefits of decriminalization should be enjoyed equally. This includes protecting against discrimination on the basis of HIV status, gender, sexual orientation, gender identity, race, ethnicity, age and nationality among others. Regular monitoring, particularly to capture any negative impacts of decriminalization processes on marginalized or disadvantaged communities is vital to ensuring a decriminalization model that works effectively and fairly *(28)*. For example, to protect against decriminalization models that become discriminatory in practice, law enforcement actors must meet human rights standards of non-discrimination and be subject to rigorous monitoring *(15, 28)*.
- **Accountability and oversight.** Accessible information regarding proposed decriminalization reforms is a cornerstone of transparency. How decisions around decriminalization are made, who is included in the process and how these processes can be scrutinized and public bodies held accountable are equally fundamental. Governments should ensure constructive forms of accountability that enable ongoing monitoring, review and remedial action to strengthen human rights and public health outcomes throughout the processes of decriminalization as well as once reforms are implemented. Adaptability is a key component of remedial action, particularly as drug consumption patterns and drug markets change *(28)*.

Good practice principle

- Alternatives to criminalization and incarceration should be developed using a human rights and public health-based approach.

1.7.2 People who use drugs must be at the centre of the response

> Policymakers usually don't talk with people who use drugs. When I look at these high-level politicians who make decisions, I see they do not understand how it works. They do not understand how it impacts people, but they start to understand when you explain and show it to them."
>
> - Community respondent

While this is mentioned above, the principle of participation is important enough to require additional attention. The participation of people who use drugs is essential in both the design and implementation of the decriminalization of drug use and possession for personal use.

The Global AIDS Strategy 2021-2026 includes a commitment to provide communities with the resources and support they need to fulfil their role and potential as key partners in the HIV response. It also includes a target that 60% of programmes on societal enablers, including enabling legal environments and the removal of laws criminalizing small amounts of drugs, should be led by community-led organizations, including organizations led by people who use drugs *(13)*.

Since the early days of punitive approaches to drug use, people who use drugs have been excluded from decisions that directly impact the many terrains of their lives. Data gathered by UNAIDS indicates that organizations led by people who use drugs are one of the least likely to be included in policy-making processes, with only prisoners being more excluded *(96)*. Decriminalization reforms that recognize and capitalize on the knowledge and wisdom of those with experience of drug use, and that enable drug policy activists and other human rights defenders to engage in the process, are vital for providing people who use drugs with the dignified support they want and are entitled to receive.

Good practice principle

- People who use drugs should be supported, including financially, to participate meaningfully in the development, implementation and monitoring of the decriminalization of drug use and possession for personal use.

1.7.3 An intersectional and non-discriminatory approach

> Only some people experience policing—not all people who use drugs, but particularly people with different vulnerabilities—how do we incorporate this intersectional perspective?"
>
> - Community respondent

For decriminalization frameworks to succeed and realize individuals' human rights, they must be intersectional *(18, 97)*. This means that they must recognize the multiple and intersecting forms of discrimination faced by specific groups and must be designed and implemented accordingly to ensure these communities are not excluded from drug law reform or continue to be harmed by drug policies.

Models must take into consideration the disproportionate impact of punitive policies on racialized and marginalized groups and address the structural factors of such disproportionate impacts. This is especially important in humanitarian crises and emergency settings where the removal of criminal penalties for drug use is crucial. Decriminalization minimizes barriers to life-saving health services, enables effective harm reduction and upholds the rights and dignity of marginalized populations whose vulnerabilities are heightened in such contexts *(18, 24, 35, 57)*.

> Those excluded from the benefits of decriminalization in practice are often the most marginalized in terms of class, race and gender, whether it is black people, LGBTQIA+, sex workers and women."
>
> - Community respondent

In the community consultation that was organized to inform the development of the *Guidance note*, participants from countries with decriminalization models advised that there is significant inequality in many existing models of drug law reforms.

Some reasons given for this were police practices. Participants advised that police operations target racialized people, LGBTQIA+ people, sex workers, poorer people, homeless people and people who are drug dependent. Police and other actors in the criminal justice system may also discriminate against these communities by treating them as people supplying, not using, drugs—a problem created by design issues in decriminalization models, such as legally uncertain threshold quantities which is then fuelled by problems in its implementation, such as discriminatory decision-making by criminal justice actors. Reports of women being sexually harassed by police under the auspice of drug law enforcement were also highlighted in community consultations.

Good practice principle

- To ensure the decriminalization of drug use and possession for personal use and harm reduction services are intersectional, policies and practices need to address the diverse and overlapping identities and experiences of people affected by drug laws and drug-related harm. This is in recognition that drug policies disproportionately affect marginalized groups, including people of colour, lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual individuals (LGBTQIA+), sex workers, racialized communities, women, young people, people living with HIV, people with disabilities and economically disadvantaged communities.

1.7.4 A public health approach

When looking at which laws need to be reformed, and how, as well as the broader interventions necessary, the impact on health should be a primary consideration.

Decriminalization of drug use and possession for personal use is key to an environment in which people can access HIV and other treatment. However, as equally important as the decriminalization of drug possession are reforms of laws that criminalize the possession of syringes and other harm reduction equipment (drug paraphernalia laws).

Calls to decriminalize the possession and supply of this equipment has been at the heart of the HIV response since its early days, with the 1996 International Guidelines on Human Rights and HIV calling for the repeal or review of laws targeting specific vulnerable groups *(98)*. These laws severely hinder the provision of, and access to, crucial HIV prevention methods, such as NSPs, undermining individuals' right to health *(9, 10, 99, 100)*.

Likewise, if removed, laws that criminalize the provision of harm reduction advice,– for example, drug propaganda laws or those that treat harm reduction advice as incitement of a crime, will also assist facilitate more effective HIV responses.

Laws that criminalize the sharing of drugs among peers without profit (often referred to as social supply) risk the continued criminalization of people who use drugs and thus the same consequent harms in terms of inhibited access to treatment. As such, decriminalization models that also decriminalize social supply, i.e. supply without profit, as well as supply where profit funds personal use, will be important to an enabling environment for HIV responses *(101)*. The laws that need to be reformed as part of the decriminalization of drug use and possession for personal use are discussed further in Part 2.

> Drug policy reform and a world after the war on drugs should also include people who sell drugs."
>
> Community respondent

As discussed in Part 2, similar considerations also need to be made in relation to State responses to drug use and possession for personal use, such as the impact of administrative fines or treatment options.

In the community consultation, many participants expressed that, for decriminalization models to be more effective, they should not be limited to possession only. Effective decriminalization models should encompass other activities, such as low-level profitable supply, supply without profit and cultivation.

> If we want to remove the criminalization of drug use, we need to think about changes to how we punish supply, otherwise it will be toothless. For example, here if I take drugs here and give them for free to somebody else, it will be considered in the court as distribution. Prisons are full of people who use drugs and who gave drugs to other people without profit."
>
> - Community respondent

It is crucial that national policies reflect this nexus. In practice, national drug policies should outline how their strategy will reduce the risk of HIV and viral hepatitis transmission and improve access to HIV and viral hepatitis treatment; this should provide a clear commitment to decriminalization and upscaling harm reduction responses as part of these goals.

Equally, national HIV and blood-borne viruses prevention and treatment strategies should state clearly the need for a legally enabling environment and decriminalize, or commit to decriminalizing, drug use and possession for personal use and other relevant ancillary offences.

In operationalizing these policies, health ministries should be responsible for, as well as leading, the health needs of people who use drugs, including responsibility for oversight of the decriminalization framework.

1.7.5 Monitoring impact—ensuring the decriminalization of drug use and possession for personal use is effectively implemented as part of the HIV response

Monitoring the impact of any model of decriminalization is a key element to ensuring the framework is protecting the human rights and health of people who use drugs, including reducing the risk of HIV transmission and maximizing treatment engagement. Community-led monitoring and evaluation of the implementation of decriminalization, broader social services, is a core requirement of the implementation process *(25)*.

Any model of decriminalization must work effectively and fairly and ensure there is accountability in the system, particularly with regards to police practices and inequitable application of the law. Monitoring should capture any negative impacts of decriminalization on marginalized communities such as on HIV and other health outcomes, including but not limited to marginalization on the basis of race, age, socio-economic status, involvement in sex work, sexual orientation, gender identity, sex, race or ethnicity as well as the intersection of any of these characteristics. Where discriminatory practices are identified, adaptions must be made to ensure equitable application of the law.

In addition, in developing any model of decriminalization a review of other laws that negatively impact people who use drugs, especially those who come from intersecting and oppressed groups, should be undertaken and reformed. This would include reforming laws relating to sex work, HIV status and risk of transmission, same-sex relationships, gender identity and expression, public nuisance laws and laws used to punish homelessness (such as loitering and vagrancy laws).

Adaptability is a key component of any model. Drug consumption patterns and drug markets change and so flexibility in the system is crucial.

1.7.6 What is needed beyond criminal law reform?

One of the key reasons for decriminalizing drug use as part of the HIV response is to remove barriers to accessing HIV services, including harm reduction services, and reduce stigma and discrimination. There are, however, limitations to what can be achieved by the decriminalization of drug use and possession for personal use where this is not accompanied by wider social reform. For a broader rights-based approach that maximizes the potential benefits of decriminalization in the HIV response, the decriminalization of drug use and possession for personal use should sit alongside support and investment in HIV services, harm reduction and broader health programmes. This is because the decriminalization of drug use and possession for personal use is necessary, but not solely responsible or sufficient for the positive outcomes evident in countries with decriminalization models.

Much of the evidence to date is from countries where there has been—at least for a period—–investment and support for harm reduction, treatment and other social services, alongside drug law reform.

Scaling up of evidence-based approaches such as NSPs, OAMT, HIV and HCV testing and treatment, alongside the decriminalization of drug use and possession for personal use, will achieve better health outcomes and reduced HIV transmission rates. According to the WHO guidelines on HIV and HCV for people who inject drugs,:

"The impact of NSP and OAMT on both HIV and HCV is well established *(2-6)*. Importantly, modelling shows that impact on both HIV and HCV and related public health benefits are more likely when a combination of harm reduction approaches is used, that is, both NSP and OAMT, and at a sufficient scale *(102, 103)*. Further, modelling also shows that while scaling up NSP and OAMT will reduce HIV and HCV incidence considerably (in one United Republic of Tanzania model by 62.6% and 81.4% respectively, from 2019 to 2030), scaled-up antiretroviral therapy, alongside full NSP and OAMT, will further decrease HIV incidence, particularly when sexual transmission is also reduced, and HCV treatment alongside harm reduction will significantly decrease HCV incidence (by 92.4% over 10 years in the United Republic of Tanzania model)" *(103, 104)*.

The WHO recommended package of interventions for key populations in relation to HIV, viral hepatitis and STIs, also supported by UNODC and INPUD in the publication, *Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people who inject drugs* includes the following as necessary for prevention, testing and treatment of HIV *(26, 71)*.

Essential for impact: enabling interventions
Removing punitive laws, policies and practices
Reducing stigma and discrimination
Community empowerment
Addressing violence
Essential for impact: health interventions
Prevention of HIV, viral hepatitis and STIs
Harm reduction (NSPs, OAMT and naloxone for overdose management)
Condoms and lubricants
Pre-exposure prophylaxis for HIV
Post-exposure prophylaxis for HIV and STIs
Prevention of vertical transmission of HIV, syphilis and HBV
Hepatitis B vaccination
Addressing chemsex
Diagnosis
HIV testing services
STI testing
Hepatitis B and C testing

Treatment
HIV treatment
Screening, diagnosis, treatment and prevention of HIV-associated tuberculosis
STI treatment
HBV and HCV treatment
Essential for broader health: health interventions
Conception and pregnancy care
Contraception
Mental health
Prevention, assessment and treatment of cervical cancer
Safe abortion
Screening and treatment for hazardous and harmful alcohol and other substance use
Tuberculosis prevention, screening, diagnosis and treatment

Policymakers must be clear about what benefits the decriminalization of drug use and possession for personal use can provide in the absence of further reform. For example, decriminalization alone may have a limited effect on HIV without further access to sterile needles and syringes or OAMT.

In order to best protect public health and achieve the right to health, States must *also* fund and support low threshold access to harm reduction and OAMT *(26)*. Safer supply models[12] and drug-checking services have also been used successfully to reduce harm associated with illicit drug use *(105, 106)*. The benefits of these services will also be maximized by the decriminalization of drug use and possession for personal use, which will facilitate greater engagement by removing the fear of criminalization and stigma for those needing to access these services. Divesting from the war on drugs can also free up resources to reinvest in health and harm reduction services, creating a pathway for an approach grounded in public health and human rights that is also based on the best available scientific evidence *(18)*.

Such services must be non-discriminatory and intersectional; for example, by ensuring the availability of gender-sensitive services or building expertise on the drugs that specific communities use. Services and projects must specifically address the needs of marginalized people, such as people who use drugs dependently, racialized people, women, LGBTQIA+ people, people with disabilities and sex workers. Key towards achieving this is the meaningful

> The resounding consensus in the community consultation, as well as in the academic literature, was that decriminalization must be accompanied by investment in the comprehensive package of harm reduction services, as defined by UNODC, WHO, INPUD and UNAIDS and wider social reform. Crucially, this requires reform related to housing and wider access to other economic, social, and cultural rights.
>
> Decriminalization of drug use must be part of broader social reform and increased harm reduction housing for people who use drugs."
>
> Community respondent

[12] Safer supply is a harm reduction intervention designed for individuals at risk of overdose due to a toxic illicit drug market. Safer supply involves prescribing drugs to people as an alternative to the drugs usually obtained from the illicit drug market. It is not focused on stopping drug use but aims to keep people alive.

engagement and leadership of these communities in the design, delivery and monitoring of these services.

> It is often hard to pinpoint positive effects on decriminalization alone. Many of the positives come from the investment in harm reduction, especially peer-led services, where we provide what people need, not only what outsiders think they want."
>
> - Community respondent

Social determinants of health. *The decriminalization of drug use and possession for personal use is necessary but not sufficient.* Stigma and discrimination exclude people who use drugs from many aspects of ordinary social and family life, trapping them in cycles of social, economic and political marginalization. Any decriminalization process should aim to maximize **social determinants of health** for people who drugs, which may include reforms that enable access to work, social protection, housing, family support and educational opportunities. These systems and services may take time to build. Their absence or current weakness should not preclude decriminalization happening now *(28)*.

In the community consultation, participants identified examples of how services can facilitate meaningful engagement of people who use drugs, including non-discrimination against drug use in employment policies, employment arrangements that are responsive to the realities of drug dependence or housing precarity and productive partnerships with community organizations led by people who use drugs.

Good practice principles

- In parallel with the decriminalization of drug use and possession for personal use, investment must be made in the provision of affordable, accessible, acceptable and good quality harm reduction services and evidence-based treatment that are non-discriminatory in line with the WHO recommended package of interventions.
- Address underlying social determinants of health, including housing, work, social protection, educational opportunities and family support.

PART 2

This section of the *Guidance note* looks at the main key areas of law reform involved in the decriminalization of possession of drugs for personal use. It reviews different approaches in each of these areas and their impact on the right to health, in particular HIV.

2.1 What laws and policies need to be reviewed?

Criminal penalties may attach to a number of activities relating to drug use that then have a negative impact on health and wellbeing, including HIV outcomes. To ensure the process of the decriminalization of drug use and possession for personal use is effective, all laws that may prevent or undermine the provision of or access to services or increase health risks should be reviewed. Depending on the country context this may include, but is not limited to:

1. **Possession of drugs for personal use.**
2. **Consumption of drugs, including in public, by people under 18 and during pregnancy.**
3. **Purchase of drugs for personal use.**
4. **Cultivation of drugs for personal use.**
5. **Sharing and selling of drugs for subsistence, to support personal drug use costs and to provide a safe supply (i.**e. necessity trafficking) *(1).*
6. **Ancillary laws and policies that discriminate against people who use drugs, examples include drug paraphernalia laws (for example possession and/or supply of needles and syringes), drug user registers, drug propaganda laws, evictions based on drug-related activities, loss of employment, school expulsions, forced drug tests, deportation and limitation of child and parental rights.** Not all of these are within the scope of the *Guidance note*.
7. **Administrative sanctions, where they have replaced criminal sanctions, should also be reviewed.** This applies not only to existing systems of decriminalization, but also to legal frameworks that punish ancillary activities, such as possession and/or supply of drug paraphernalia or public drug use. Experience shows that administrative consequences (such as fines or loss of social security) can have similar negative effects on health and other human rights as criminal sanctions.

In the community consultation, there was a strong sense that when decriminalization is limited to personal possession, the same communities of people using drugs continue to be criminalized under supply laws for supply without remuneration (social supply or sharing).

Approaches to each of these issues will have implications for both public health and human rights. The majority of country examples explored in this section do not criminalize consumption or purchase. There are a limited number of examples

that extend decriminalization to cultivation for personal use and/or sharing of drugs without profit. These are not the focus of the *Guidance note* but may be referred to briefly in the sections below.

In developing decriminalization models, consideration must be given as to how to determine:

- Whether there has been an offence; for example, whether drugs in a person's possession are for personal use and what evidence is required.
- Who determines the offence: a police officer, a prosecutor or a court, or some other body.
- What the response should be to drug possession for personal use.

These three issues are discussed in detail in the sections below.

Good practice principles

Drug decriminalization efforts should seek to remove all criminal penalties for minor non-violent drug offences that, in review with communities, have been identified as undermining the HIV response and broader public health efforts, including but not limited to drug use, possession for personal use, possession of drug related paraphernalia.

2.2 Defining 'for personal use'–including the role of threshold quantities and other approaches

When decriminalizing drug use and possession for personal use, a key consideration is how to differentiate between individuals possessing drugs for their own personal use, versus those possessing drugs with intent to produce, supply, sell or traffic for profit. Following both human rights and criminal law principles, the assumption of innocence until proven guilty must be maintained, meaning in the absence of evidence that a person is committing a crime (such as trafficking), the person should be presumed innocent. This differentiation should be done in a way that also reduces lengthy (or any) interaction with law enforcement and the justice system for those possessing drugs for personal use.

Approaches to determining whether possession for personal use differs between jurisdictions, with a number of different approaches being used.

TQs are used by some jurisdictions to determine whether the drugs in someone's possession are for personal use, rather than supply, and thus fall within the decriminalized activity of personal possession.

In most cases, the government, court or a designated body sets TQs or limits the amount of drugs a person can possess for it to be considered personal

use. TQs are often the element of the decriminalization of drug use and possession for personal use that receives the most attention, both prior to and post-implementation, despite the fact that there is no systematic approach to developing these quantities with significant variations across different jurisdictions.

The way in which TQs are utilized also varies. TQs can be:

Binding (sometimes known as determinative), meaning that there is no additional evidence required to arrest and charge a person with trafficking or supply for possession above a certain amount, or for criminal possession where that offence is retained.

Indicative, meaning that the TQ can help inform a decision as to whether someone is in possession of drugs for their own personal use. However, the TQ is not the sole factor that is considered and additional evidence is required for a charge of supply or distribution *(2, 3)*.

Other jurisdictions may not set specific TQs, but instead use terms such as 'a small amount' or 'a reasonable amount' of drugs, while others may have no limits and rely instead on whether there is evidence of criminal activity, e.g. trafficking.

Communities report that the way personal use is determined can have significant impacts on HIV, broader health and other rights. If TQs are set too low, or there is uncertainty, then many people possessing drugs for personal use may end up unjustly arrested, prosecuted and potentially convicted of trafficking, undermining the entire purpose of the decriminalization of drug use and possession for personal use.

Individuals may also consume their drugs quickly so as not to be caught with amounts over the TQ, which can lead to increased harm, including needle sharing and therefore higher risk of HIV acquisition and overdose.

At the same time, the absence of TQs can give law enforcement more discretion but may also be open to abuse and inconsistent implementation, creating increased uncertainty for people who use drugs, (which can again increase risk-taking behaviours).

The Working Group on Arbitrary Detention's report on arbitrary detention relating to drug policies notes,

> "The classification of the amount of a drug that exceeds what is considered reasonable for personal use frequently creates a legal presumption in national law of a trafficking offence, with severe criminal penalties. In some States, the quantity is set quite low or no definition is provided at all, facilitating arbitrary detention of people who use or possess drugs in small quantities for personal use." (4)

2.2.1 Global overview

More than two-thirds of the 39 countries that have decriminalization frameworks in respect of drug use and possession for personal use utilize TQs in some form, and most use the weight of the substance to establish the TQ while some use both purity and weight. *(2,3)*.

There is significant variation in the weights used as TQs in countries and in the method of determining those weights. Portugal for example, uses the concept of ten days use to develop TQs, while Spain uses an estimation of five days use, despite this, Spain has higher TQs than Portugal *(5,7)*. Additional information and other examples are found below.

While country examples detailed below demonstrate this variation, the range runs from 0.05 grams of heroin or 0.5 grams of cocaine in Mexico (binding), to 3 grams of heroin and 7.5 grams of cocaine in Spain (indicative). The level of active ingredient in a drug, along with the weight of the drugs, is used to determine the TQs in Czechia.

Reviews of this approach have found that using purity or active ingredient as a basis for TQs is problematic as people who use drugs cannot be expected to know exactly what is in their drugs due to the illicit nature of the market, and verification in laboratories can be a costly, time-consuming process and are also limited in terms of availability to people who use drugs *(3, 8)*.

Some countries have pointed to INCB's "defined daily dose for statistical purposes" (S-DDD) as a guide for TQs. However, INCB has been clear that this is a "technical unit of measurement for the purpose of statistical analysis and is not a recommended prescription dose. Its definition is not free of a certain degree of arbitrariness." As such, the S-DDD is not intended to inform TQs *(9)*.

Eleven of the 39 countries that have decriminalization frameworks do not use TQs at all. Instead, they use more vague terms such as 'reasonable quantity', 'small quantity' or require evidence that there was no intention to supply for profit, preferring to make a determination on a case-by-case basis *(2)*.

2.2.2 Country examples

Portugal. Portugal decriminalized drug possession in 2001. The TQs in Portugal were set at 10 days' worth of average daily dose of drugs for personal use, this was defined as 25 grams of herbal cannabis, 5 grams cannabis resin, 2 grams of MDMA (ecstasy), 2 grams of cocaine and 1 gram of heroin *(10)*. The view in the community consultation was that TQs set at this level disadvantaged people using drugs dependently or more frequently. In the first few years of the new law, possession of an amount above that TQ was indicative, meaning would only be prosecuted if there also evidence of supply.

A 2008 Supreme Court decision held that anyone caught with drugs above the TQ amount should be subject to criminal prosecution for possession, rendering the TQ of 10 days' use binding *(11)*.

In the community consultation, the view of participants from Portugal was that the 2008 decision effectively recriminalized drugs for people using dependently, frequently or living rurally and travelling into cities to bulk-buy drugs to last weeks or months.

In 2023, Portugal legislated back to indicative TQs in recognition that people caught above the TQ should not be criminalized for personal use of drugs as this was in contradiction of the overall policy approach of decriminalization of use and possession *(5)*.

A combination of decriminalization and provision of harm reduction services has seen a significant decline in annual numbers of new HIV infections among people who inject drugs. European Centre for Disease Prevention and Control data from 2004 reported 973 new cases among people who inject drugs declining to 24 new cases in 2023 *(12, 13)*.

Spain. Spain uses a combination of indicative TQs and evidence of intention to supply with financial gain. Unlike Portugal, TQs in Spain are not found in legislation, but come from a report that was prepared by the Instituto Nacional de Toxicología in 2001, which has been frequently cited in case-law of the Supreme Court. Spanish TQs are based on an average personal dose of five days, equating to 100 grams of cannabis, 25 grams of cannabis resin, 2.4 grams of ecstasy, 3 grams of heroin or 7.5 grams of cocaine *(14, 15)*. As Spain's model of decriminalization only criminalizes supply where there is a financial profit, prosecutions will only be brought where there is evidence of supply and intention of financial gain.

In the community consultation, the advice was that the use of indicative TQs has been a positive development. Spain has also seen a decline in annual HIV infections; over the same period, 2005-2023, the numbers of new HIV infections among people who inject drugs dropped from over 200 to 55 *(12, 13)*.

Poland. There are no TQs in Poland, and while possession of any amount of drug can be prosecuted, prosecutors and courts have the option of discontinuing proceedings based on whether a person has a small quantity of the drug in their possession *(16)*. Prosecutions for drug possession remain high, with 89% of all drug offences in 2015 being for possession as opposed to supply *(17)*. One reason given for this by community members is the lack of TQs, resulting in inconsistent application of the law. Participants in the community consultation advised that, while prosecutors can dismiss drug possession cases, in practice this tool is rarely used and, instead, participants felt drug laws continue to be a tool to criminalize poverty. Participants also emphasized the problematic legal uncertainty caused by the absence of TQs.

Australia. Australian Capital Territory (ACT). The ACT decriminalized possession of cannabis in late 1992, setting the TQ at 25 grams and set up diversion programmes for several other drugs in 2001 *(18, 19)*.

In 2013, there was an evaluation of the scheme involving law enforcement, people who use drugs, legal aid and treatment providers. Following the evaluation, the TQ levels for cannabis and other drugs were increased as it was found that very few people were being put through diversion programmes for possession of heroin, MDMA, cocaine or methamphetamines, indicating the TQs were too low *(19)*. This demonstrates the importance of evaluating the impact of TQs and adapting the framework to ensure it incorporates all people who use drugs. The ACT has gone on to be the first Australian territory or state to decriminalize all drugs, setting the TQ at 1.5 grams for most substances and 1 gram for heroin *(20)*.

Canada. British Columbia. In setting thresholds, British Columbia's Ministry of Mental Health and Addiction initially proposed the TQ should be set at 4.5 grams cumulatively, meaning that people could be in possession of several substances up to this TQ, including opioids, MDMA, methamphetamine and cocaine. This proposed TQ was based on consultations, including with community members, and on existing research reflecting patterns of drug use, including people in rural areas who travel to secure an amount that can last for several days *(21)*. The final TQ of 2.5 grams were closer to police recommendations of 1 gram and was criticized by user-led organizations and other advocacy groups *(21, 22)*. Other than increased health harms, people who use drugs have expressed concerns linked to having to purchase more frequently from the illicit market, thus increasing risks of overdose due to changes in quality or contamination *(21)*.

2.2.3 Benefits and challenges of different approaches

If implemented well, evidence from communities and implementation reviews indicates TQs can provide clarity in the legal framework, both for people who use drugs and those responsible for determining the offence (for example, the police), thereby reducing the risk of discriminatory, arbitrary, inconsistent or unfair decisions and unnecessary interactions with law enforcement and the courts.

Combined with TQs that are adequately set, these two elements allow individuals to better protect their health and well-being, providing them with greater control over when and how they consume drugs and reducing the sharing of needles and syringes. In addition, the principle of legality requires the scope, meaning and effect of the law to be sufficiently clear, precise and public. Vague laws that confer excessive discretion can lead to arbitrary decision-making and are incompatible with human rights *(23)*.

> Thresholds are better than no thresholds. Having no thresholds mean there is a lack of legal certainty. There is nothing that prosecutors are bound to follow when prosecuting."
>
> - Community respondent

Using terms such as 'reasonable' or 'small' without additional clarification, lacks legal certainty, meaning that people who use drugs do not know when they may be at risk of criminalization, either for possession or a more serious offence. It also provides a significant amount of police discretion in how a system operates, all of which can increase the fear of law enforcement apprehension and the likelihood that drugs may be consumed hurriedly and without adequate safety precautions *(3,25)*.

In the community consultation, participants from countries with undefined thresholds, where terms such as 'reasonable' or 'small' are used, flagged concerns around police corruption and the impact of legal uncertainty, especially on marginalized groups. The view of these participants was that people of certain racial or socioeconomic status are more likely to be on the receiving end of arbitrary, discretionary decisions at the hands of the police.

Setting TQs too low will disadvantage people who use dependently or frequently, people with higher tolerances to drugs and those who prefer to buy in bulk—such as to limit travel from rural areas or to limit contact with the illicit market)—placing them at increased risk of prosecution for criminal possession or supply offences.

As was expressed in the community consultation, most of the existing TQs are low and automatically disadvantage people who have higher tolerances levels, including people who are drug dependent and more likely to buy drugs in quantities above the thresholds and then be criminalized.

The use of indicative, rather than binding TQs, also helps avoid arbitrary criminalization of people who use drugs and who possess amounts above the TQ. The 2023 law reforms by Portugal to reverse the Supreme Court decision that created binding thresholds on the basis that it undermined the purposes of decriminalization is an example of that *(5)*. In Brazil, when the Supreme Court held that possession of cannabis for personal use was not a criminal offence, they also set an indicative threshold for possession for personal use, with a number of judges noting that in doing so they were protecting against discrimination on the basis of race and economic status. *(24)*

The advice from the community consultation was that, in any system with thresholds, exceeding the threshold should not create a presumption of intention of supply, which shifts the onus of proof on to the defendant. It should fall on the prosecution to prove the intent to supply with additional evidence beyond the mere amount of drugs.

Participants also voiced that the absence of thresholds facilitates police to categorize marginalized people as suppliers and traffickers based on discriminatory profiling of the appearance or the identity of the individual. Flexibility in how TQs are used has been found to help avoid some of these issues. Experts in the field talk about implementing a TQ model where the amounts are a floor not a ceiling.,. In this approach, any amount below the TQ is considered for personal use. Possession for an amount above the TQ does not automatically

mean that the individual is engaged in criminal activity, rather, additional evidence of criminal activity (e.g. trafficking) is required. This recognizes that there are varying patterns of drug use and that carrying amounts over the threshold does not necessarily indicate trafficking *(3, 21)*.

> Thresholds should be flexible and there should be a commission where community has a place and is listened to regarding these issues."
>
> - Community respondent from Portugal

While not addressed in the examples above, research on the use of purity in TQs has indicated that there are significant problems with this approach. It is unlikely that most sellers and purchasers know the purity levels of a substance, especially with fluctuating levels. Any requirement for law enforcement to assess purity would lead to a delay in determining whether a person should be subject to the decriminalized framework or prosecuted *(3)*.

TQs developed in consultation with people who use drugs will more accurately reflect the different patterns of use and changes in the drug market as well as diverse needs; for example, if people have to travel to purchase drugs. This can also help prevent the need for more frequent purchasing or rushed consumption, which can be associated with overdose, needle sharing or other health harms *(3)*. Periodic studies by experts in this area can also be useful when setting TQs as seen in the Australian example above.

> One thing we did here in Oregon that I thought was a good way to engage community was to create a council that mandated representation from people who use drugs, as well as people from diverse locations, racial diversity and people who have been involved with the criminal legal system."
>
> - Community respondent

The consensus in the community consultation was that, when determining TQs, the meaningful and ongoing participation of people who use drugs is essential; for example, through regular public consultations or governmental commissions, where people who use drugs are represented.

Monitoring and evaluation of TQs is critical to ensuring that the TQs are operating effectively in keeping people who use drugs away from the criminal justice system.

2.2.4 Good practice principles for determining use versus supply

Drawing from the evidence and expert and community consultations, the principles below aim to assist in the creation of systems that reduce the risk of recriminalization, stigma and health-related harms associated with engagement with law enforcement, therefore increasing the likelihood of people accessing and using health services and reducing HIV risk.

Good practice principles

The criteria for distinguishing between drug possession for personal use and possession for supply for profit should create certainty and clarity among people who use drugs and for the criminal justice system.

In the development of any threshold TQs or other methods for determining use versus supply:

- The diversity of needs and experiences of people who use drugs, including diversity in quantities and types of drugs consumed, should be taken into account.

- The health and wellbeing- of people who use drugs, including the ability to control when and how they both acquire and consume drugs, and their ability to source and utilize sterile injecting equipment, must be protected.
- People who use drugs must be able to understand the criteria for personal use and know whether or not they fall within those criteria.
- TQs must not disadvantage or discriminate against people based on, for example, their tolerance, dependence, frequency of use or rural location.

– The basic principles of criminal law must be respected.

– The onus of proof for establishing intent to supply with financial gain should remain with the prosecution. Individuals must be presumed innocent until proven guilty beyond a reasonable doubt. Simple possession of a certain amount of drugs should not create a presumption of intent to supply.

- People should be protected from arbitrary detention.

– The use of TQs is preferable to no limits or vague limits, providing greater legal certainty for people using drugs.

– The establishment of TQs, and how they are used, must be established following meaningful consultation with communities of people using drugs, particularly those using drugs dependently or those who need to bulk purchase due to difficulties in accessing drug markets.

– TQs should be set at a sufficiently high level to avoid creating risk behaviours such as rushed consumption/injection or needle sharing. They should be based on weight only to ensure people who use drugs can control whether they are within the TQ.

– Threshold quantities should be indicative. Possession of drugs above the threshold amount should not be considered criminal activity without additional evidence (a floor not a ceiling approach).

Law enforcement should be trained on how TQs work, including that amounts above the TQs are not proof of supply and should not be used as a basis to bring a prosecution.

2.3 Who determines the offence and who decides the consequences

Determination of the offence relates to the decision-making powers of various actors in the criminal justice system. For example, can a police officer decide not to search or arrest an individual suspected of possessing drugs only for their own

personal use? Can that officer also decide whether to issue a fine or divert them to health and social services? Or is it a prosecutor, judge or other actor who decides if a person falls within the decriminalization model and what the response should be?

For most countries across the world that have ended criminal sanctions for specific drug-related activities, the decision-maker will usually either be the police, the prosecutor and/or the judiciary *(25)*.

The approach here can have significant impacts on HIV and other health and human rights outcomes. Evidence has shown that mere interaction with law enforcement can impact on health seeking behaviours, so the extent to which a person is able to reduce police contact is important *(26)*.

2.3.1 Global overview

In the majority of approaches to the decriminalization of drug use and possession for personal use models, it is usually the police who will determine whether someone will be dealt with through a decriminalized framework or whether they will be arrested for the purposes of a criminal investigation, such as for alleged supply or possession above a TQ. Depending on the model, it may then be the police who decide whether to refer individuals to health and social services or to issue administrative penalties, such as fines or warning, or they may be required to detain the person while a determination is made by judicial authorities *(2)*.

This does not mean law enforcement necessarily interacts with every person suspected of possessing drugs or even that they are permitted to do so. Models that seek to reduce police interaction, largely through the removal of legal powers to search people suspected of being in possession of drugs for their own personal use, operate in some jurisdictions. This was the case in Oregon, where police did not have the power to search people suspected of possession for personal use, but where drugs below a TQ were found as part of a search related to separate suspected criminal activity. In such cases, a fine could be issued and the fine could be waived if the person contacted a helpline for voluntary referral to services *(27, 28)*. The West African Model Drug Law takes a similar approach, stating that suspicion of a person possessing drugs for their personal use is not sufficient grounds for arrest *(29)*.

At the other end of the spectrum, there are some examples of prosecutorial involvement, such as in Poland and Germany *(2)*. In the Netherlands, prosecutorial guidance informed policing practices within a de facto decriminalized system *(30, 31)*. In other countries, a separate body is created to decide on non-criminal responses, as is the case with Portugal's dissuasion committees. In Latin American countries, it largely falls to the judiciary to determine whether the person is subject to criminal prosecution, but this can recreate the same harm of criminalization, such as rushed consumption, needle-sharing or avoidance of harm reduction services.

2.3.2 Country examples

The role of police in determining the offence

Portugal. In Portugal, reasonable suspicion of the possession of any quantity of drugs is still sufficient basis for law enforcement to apprehend and search individuals. Where police determine there is no evidence of supply, they will divert the individual to a dissuasion commission which then determines whether proceedings should be suspended or if the person should be sanctioned *(6, 10)*.

In the first 10 years of decriminalization, the number of people coming into formal contact with police for drug possession remained roughly the same as the numbers before 2001 when the activity was criminalized *(32)*. There was a significant increase post-2010, indicating increased policing activity related to drug possession *(33)*.

Community members from Portugal highlight that police continue to disproportionately stop and search those who are marginalized and disenfranchised, with reports of police harassment and violence, including sexual harassment and pressure to reveal their supplier *(34)*.

Colombia. Colombia's Constitutional Court decriminalized possession of drugs in 1994 *(35)*. At various points, Colombian governments have provided police with powers to fine people caught carrying and/or using drugs in public spaces *(36)*.

A 2023 Constitutional Court deemed absolute prohibition of public possession or consumption of drugs to be unconstitutional and struck down the law. The court instructed local governments, with guidance from the Ministry of Justice, to amend local policing protocols *(37)*. The Ministry of Justice has now issued this guidance to local municipalities, advising that local policing protocols be developed *(38)*. People who use drugs have reported being detained for lengthy periods and being extorted by Colombian police officers *(2)*. In the community consultations, participants described the psychological harm of over-policing and also reported instances of serious police corruption; for example, planting drugs on individuals so that they are above the TQ.

United Kingdom. The UK has two pieces of legislation relating to drug use. The Misuse of Drugs Act 1971 criminalizes the possession of the most commonly controlled drugs, such as cannabis, heroin and cocaine, this is why the UK is not included in the countries that have decriminalized. However, there is a separate legal framework for new psychoactive substances that do not fall within the ambit of the 1971 legislation. The Psychoactive Substances Act 2016 does not include possession as an offence, technically decriminalizing possession of these substances. The 2016 Act also does not provide police the power to search people for possession of these drugs unless a more serious offence is suspected, for example supply of drugs *(39)*.

The role of prosecutors in determining the offence

Germany. Germany's decriminalization model requires that local prosecutors decide whether a prosecution should be brought against a person. The TQs are indicative, not determinative, and the decision to prosecute is a discretionary one; therefore, people caught below the TQ can still be subject to criminal proceedings and penalties if it is determined there is sufficient evidence to prosecute for supply *(40)*. Prosecutors are also responsible for setting the TQs, meaning there is a variation in the quantity amounts across different sub-national jurisdictions *(2, 41)*.

Poland. Similar to Germany, Polish prosecutors have the discretion not to bring criminal charges against someone caught in possession of drugs *(16)*.

Prosecutorial guidelines state that a prosecution should not be brought where:

- The amount of substance involved is a small quantity.
- The substance is for personal use.
- No major social harm was done; for example, the offence was not committed in the vicinity of a school *(16)*.

In the community consultation, participants from Poland stated that prosecutors rarely use this discretion not to prosecute and decisions not to prosecute are made arbitrarily.

The role of the judiciary in determining the offence

Uruguay. While Uruguay does not punish the use or possession of drugs, the decision as to whether a person is in possession for their own personal use, or with the intention to sell or distribute the drugs, is often determined by a judge. A report in 2019 found that Uruguay had high rates of pre-trial detention, making up approximately 70% of the total prison population. Among those on pre-trial detention approximately 23% of women and 7% of men were there for drug-related offences *(43)*.

Paraguay. Similar to Uruguay, the judiciary in Paraguay determines the offence leading to high rates of pre-trial detention for drug possession offences *(44)*. In 2013, 18% of the women's prison population and 6.4% of the men's population were held on pre-trial detention for drug possession offences *(41)*.

2.3.3 Benefits and challenges of different approaches

The community consultation highlighted that the question of what decision-making powers should be given to which actors is complex; each option carries different risks, each is open to discrimination in the application of those powers, particularly from police and particularly on the basis of race or socio-economic status. The community consultation also acknowledged the fact that any interaction with the police can create

> Encounters with police are extremely violent still [...] Black people are experiencing more violence from police and more accusations of drug dealing."
>
> - Community respondent

> There is often abuse of authority against more vulnerable populations, such as rough sleepers, sex workers and people living with HIV. There is also a lot of racism: black and indigenous people experience much more severe policing, more likely to be said to be trafficking."
>
> - Community respondent

> It's been a long time that we have had decriminalization, but we would like contact with the police to occur less and less frequently, or for that contact to be much more positive."
>
> - Community respondent from Portugal

or increase harms, including to HIV/health. Therefore, the consensus in the community consultation was that police interaction should be limited, and that ideally a no-sanction approach should be adopted unless there are reasonable grounds to believe there is an intent to supply (in a manner or to a degree that remains an offence), there should be no interaction with criminal justice actors.

Participants acknowledged while such an approach might remove a significant proportion of law enforcement interactions, it cannot remove all. In any situation where determination of possession for use versus supply is not a clear-cut case, criminal justice actors will be involved. In those cases, the guiding principle must be that interventions with criminal justice actors should be as brief and unintrusive as possible.

People who use drugs who are at heightened risk of police contact will often have had a long history of negative interactions with law enforcement. They may have experienced police harassment, violence, extortion and myriad other negative encounters. These experiences will be particularly heightened for people of colour, those from the LGBTQIA+ community, people who are homeless, sex workers and women.

The continued role of police in a model that aims to decriminalize people who use drugs to improve health outcomes and reduce behaviours that put persons at higher risk of HIV acquisition could potentially undermine those health outcomes. Evidence has shown that the presence of police can increase overdose risk, reduce the likelihood of people accessing and using harm reduction equipment and can contribute to rushed injections increasing the risk of infections and create barriers to accessing services *(45)*. Policing people who use drugs has contributed to the global epidemic of HIV and other bloodborne viruses *(26, 46)*.

Even in a decriminalization setting, continued over-policing—such as retaining police powers to stop and search people for drugs—will do little to reduce the fear of detection and is likely to increase harm.

In the community consultation, there were reports of negative police interactions from participants living in countries that have decriminalized drug possession including:

- HIV-related stigma and discrimination.
- Continued police intimidation and brutality, including sexual harassment.
- Planting of additional drugs or evidence on people.
- Police operations targeting drug services or places where homeless people live.

- Harassing people who have to use their drugs in non-private spaces, for example, homeless people.
- Racialized people and people using drugs dependently are more likely to be treated as suppliers.
- Intrusive practices, such as urine or saliva drug testing.
- Significant harm and corruption are driven by police performance quotas that target a certain number of arrests or charges.
- Police discretion leading to inequitable decisions, disadvantaging communities who are already over-policed.

Community participants felt that, where police play a role, it should be minimal and should, at most, consist only of referring people to brief harm reduction interventions, which are preferably voluntary, and peer-led.

The role of the police has been reduced through removing legal powers to search people suspected of possession of drugs for personal use as in Oregon or the UK.

One important advantage of police led models, unlike those where prosecutors or judges are involved whenever a person is found in possession of drugs, is that decisions can be made early, with people who are caught in possession of drugs experiencing less in-depth contact with the criminal justice system.

Unless there is the opportunity for expedited decisions, placing all cases relating to possession of drugs in the hands of prosecutors has led to reports of people having to wait months before they know whether they will have to attend court.

Prosecutors, however, could provide some checks and balances in a decriminalized model, establishing processes to appeal or review police decisions.

As with prosecutors, delays in the decision-making process are a fundamental problem with the judiciary being responsible for the determination of the offence, particularly where individuals are held in pre-trial detention. Pre-trial detention should never be mandatory for any offence and should only be an exceptional measure and based on an individualized determination that it is reasonable and necessary, specified in law and without vague and expansive standards *(4)*.

Additionally, models that shift the legal burden of proof onto defendants to demonstrate that the drugs in their possession were for personal use and not for supply or distribution should also be prohibited.

2.3.4 Good practice principles for who determines the offence

Drawing from the evidence and expert and community consultations, the principles below aim to assist in establishing models that reduce the risk of recriminalization and stigma faced by people who use drugs, maximizing the potential for a positive legal environment that encourages people to access services.

Good practice principles

- The minimization of contact with law enforcement, as well as with the criminal justice system generally, should be prioritized to reduce harms, including to the HIV response. Decisions on whether someone falls within the legal framework should be made as early as possible, in most cases within minutes, where the evidence is clear.
- Possession of drugs for personal use or possession of drug-related paraphernalia should not attract the attention of law enforcement.
- Limit stop and search powers to cases where there are reasonable grounds to suspect criminal activity such as intent to supply for financial gain.
- Diversion from criminal processes and sanctions should happen early to avoid lengthy delays, pre-trial detention and unnecessary, possibly costly, interactions with the criminal justice system.
- Where police have decision-making power in relation to drug possession and use, there should be clear accountability, oversight and reporting systems developed and implemented in collaboration with community-led organizations, to monitor and address discriminatory practices, potential net-widening and potential corrupt practices.
- Comprehensive training, sensitization and awareness raising among relevant public authorities, including police, should be provided to ensure effective implementation and adherence to the decriminalization policies and enable people who use drugs to feel comfortable seeking the assistance of law enforcement if needed.

2.4 Alternatives to criminal sanctions in depth

When criminal laws and sanctions[13] are removed, the question often remains as to what, if anything, to put in their place, whether it be administrative sanctions, health responses or no response at all. Each has its own implications in relation to health and human rights, with some approaches mirroring the impacts of

13 Throughout this section the terms sanctions are used to refer to punitive consequences noting not all consequences are necessarily punitive, e.g. a voluntary referral to health professionals.

criminalization. Decisions in this regard should be based on public health evidence, human rights law and in consultation with communities.

There is no evidence that punishing someone deters drug use *(47)*; in fact, some sanctions or punishments undermine public health and are in contravention of human rights obligations, ultimately replicating the harms of criminalization.

From a human rights and health perspective, any offer of treatment must be voluntary and informed consent sought. Any punishment that deprives people of their liberty is simply a continuation of the criminal approach.

The strongly held view in the community consultation was that a no-sanction model was best practice. This does not always mean that no intervention is required or offered. Where individuals request, or are in clear need of assistance, be it health-related, housing, social security or protection from harm by third parties, etc., voluntary referrals to systems and services should be offered, either by police or by social service or health personnel.

2.4.1 Global overview

Consequences for drug-related activities that are decriminalized vary widely across jurisdictions and each option will have its own impact on public health and human rights outcomes. Consequences that recreate criminal penalties, for example, through forms of administrative detention or heavy fines, may lead to similar risk-taking behaviour to criminalized environments in relation to sharing needles or avoiding harm reduction and HIV services.

One of the main approaches is to refer or divert people to treatment services. This may be anything from a one-off counselling session or connection to harm reduction services to a full treatment plan which is monitored by a drug court or other body. In some cases, the individual can choose to take up the referral or not, meaning the treatment is entirely voluntary. In other cases, particularly where there is quasi-decriminalization, the individual may be required to undertake the full treatment plan or succeed in giving up drug use, as monitored by an authorized body to avoid prosecution. In some cases this may be in a form of compulsory treatment centre, something which has been condemned as contravening multiple human rights obligations and undermining public health by a wide variety of bodies as explained below.

Some countries place individuals on a drug treatment register, which can deter people from seeking help *(48)*.

The use of administrative fines is also commonplace in the decriminalization of drug use and possession for personal use which may be on-the-spot fines issued by police or in a court system. While Spain does not punish private use of drugs, police do issue administrative fines to people for possession in public, which disproportionately impacts those who have no private space to consume substances.

Finally, some countries, including Germany, Uruguay, the Netherlands and Spain, implement a no-consequence model, deciding not to punish people who use drugs. The experience from these countries indicates that a lack of sanctions does not lead to more detrimental effects compared to those that punish drug-related activities.

The Netherlands, which has had a no consequence model in place for over three decades, has some of the lowest rates of HIV and HCV infection *(13, 49)*. Although police in Portugal refer people to a committee to determine what should happen next, over two-thirds of cases are suspended with no further action *(6)*.

2.4.2 Country examples

Diversion to treatment

Portugal. The dissuasion committees in Portugal that determine the civil penalty for possession of drugs have a range of sanction options at their disposal *(10)*. In practice, most cases are suspended with no penalty issued against the person caught in possession of drugs for their own personal use *(6)*.

As well as suspending proceedings, committees have the power to impose community service, fines, suspensions on professional licenses and bans on attending designated places *(10)*. If a person is deemed to be dependent on drugs or is having issues with drug use, a brief intervention may be offered, including counselling or a referral to treatment, both of which are undertaken on a voluntary basis *(10)*.

Participants in the community consultation stated that referrals to the committee weigh most heavily on poor people and people who are homeless and that the person using drugs is often excluded from the committee's decision on whether their drug use is problematic. Overall, participants from Portugal expressed that the current system was an improvement, though some communities have benefited more than others.

Paraguay. Although Paraguay does not punish possession of drugs below the TQ, pre-trial detention, as highlighted above, is of significant concern, seen as a de facto punishment. Additionally, if courts determine that a person is dependent on drugs they can impose compulsory treatment *(44)*.

Armenia. Possession of drugs below a small quantity in Armenia attracts an administrative fine, although the level of the fine is extremely high (100 to 200 times the minimum wage) *(50)*. The fine can be waived if a person agrees to drug treatment, which includes the option of OAMT *(50)*.

Suspension of proceedings

Portugal. As highlighted above, dissuasion committees suspend the majority of cases brought before them, this is in recognition that most people who use drugs do not need treatment referrals, voluntary or otherwise, or that any sanction is necessary.

Between 2001 and 2009, 59% to 68% of cases brought before the committee for people deemed not to have a drug dependency, were suspended with no further action *(6)*.

Financial penalties

Australia (South Australia). Although only related to cannabis possession offences, the experience of South Australia is instructive when it comes to the use of fines as a sanction. South Australia introduced the Cannabis Expiation Notice Scheme in 1987, replacing criminal sanctions with civil fines for those caught in possession of cannabis *(51)*.

In the first nine years of the scheme, the number of cannabis offences recorded increased almost threefold, believed to be because of police net widening, which was found to have disproportionately impacted on people in poverty and other underprivileged groups *(52)*.

According to a review of the system, as the fines were too high, and there was no way to pay in instalments, more people were sent to prison for non-payment of the Cannabis Expiation Notice, than had been imprisoned for cannabis possession when it was a criminal offence *(52)*. Those in the community consultation from other countries flagged the issue of non-payment of administrative sanctions that leads to criminalization further down the line. South Australia subsequently adapted the scheme by reducing the fines *(52)*.

Kyrgyzstan. Kyrgyzstan decriminalized drug possession in 2019, though penalties had been reduced since 2007. The new law introduced civil fines for possession without intent to supply range from approximately 30,000–60,000 Kyrgyzstani Som (approximately US 340US$ 680 at the time of publishing), higher than they had been under the criminal system *(53-55)*. Non-payment of the fine is a criminal offence and can attract 2.5 years in prison and additional financial penalties *(54)*. Community research has found that the initial decriminalization model meant people were more willing to identify as people who use drugs and that facilitated access to harm reduction services. However, after 2019 such high fines meant that people may be unwilling to identify as people who use drugs and access harm reduction services *(55)*.

Participants in the community consultation advised that there are issues with the decriminalization of drug use and possession for personal use existing in theory only and not in practice. Participants described ongoing advocacy efforts to reduce fines to improve upon the current system.

Confiscation of drugs

Canada (British Columbia). As described above, police officers in British Columbia cannot confiscate a person's drugs if the total amount is less than the 2.5 grams cumulative threshold.

Earlier research into police seizure of drugs in Vancouver during periods of depenalization, found that the confiscation of drugs was associated with increased risks to an individual's health *(56)*.

Drug seizures mean people are again more likely to try to consume their drugs quickly and go back to the illicit, unregulated and increasingly toxic drug market to purchase replacement substances. This places individuals at greater risk of needle sharing, overdose and potentially places them in greater indebtedness *(56)*.

No-punishment models

Spain. Spain decriminalized possession, social supply (supply without profit) and cultivation of cannabis following a 1974 Constitutional Court decision, later codified in Spanish legislation. The position of the court was that private use and sharing of controlled drugs without profit should not be criminalized or punished; therefore, private possession, social supply and cannabis cultivation are lawful and the policing of these activities is not permitted *(57)*. However, public possession is an administrative offence, which can attract a fine *(58)*.

In 2023, Spain reported 446 816 use offences to the European Union Drug Agency *(59)*. Community members from Spain in the consultation advised that policing public use and possession creates precarity. It drives people to use drugs in isolated places and leads to higher risk practices such as needle sharing due to fear of police detection.

Netherlands. The Netherlands' model of de facto decriminalization of drug use and possession for personal use (depenalization), has been in place since 1976 *(60)*. While the law itself maintained drug possession as a criminal offence, it formalized existing police and prosecutorial guidance determines that the law would not be enforced for people in possession of an amount below the TQ *(31)*.

The Netherlands has one of the lowest rates of injecting drug use in Europe *(61)*. In 2023 it had one of the lowest rates of HIV diagnosis through injecting drug use within Europe, with less than 0.3% per 100 000 population *(13)*. It is not suggested that a no-punishment model led to this decline, but it challenges the perceived notion that criminalization or some form of punitive or compulsory health response must exist to deter people from using drugs.

2.4.3 Benefits and challenges

The choice of governmental response to the possession of drugs for personal use can have significant impacts on the health, rights and well-being of individuals. Civil sanctions, such as fines, confiscation, treatment or other sanctions, have been reported to recreate some of the barriers that have been identified in relation to the use of criminal sanctions. Fear of non-criminal sanctions can still result in people who use drugs being less likely to access and use sterile needles and syringes or come forward to access health and other social services.

While the provision of treatment services or referrals do support a public health and rights-based approach if done correctly, the approaches vary widely, with some modalities, such as compulsory or quasi-compulsory treatment and event treatment detention, undermining both public health and human rights.

> People who have been both in prison and rehab continue to use drugs. They don't work as a deterrent. However, the experience traumatizes people and their families."
>
> - Community respondent

The use of mandatory treatment and administrative detention are examples of the most egregious sanctions that operate in currently decriminalized models, including compulsory drug detention centres. These centres deprive people of their liberty, violate the right to health and are associated with other significant human rights abuses and ill treatment. There have been repeated calls for their closure, including statements by the Working Group on Arbitrary Detention, the Special Rapporteur on Torture, the Special Rapporteur on Health, the Human Rights Committee, the Committee on the Rights of the Child and thirteen UN agencies, including UNAIDS, OHCHR, WHO and UNDP *(4, 25, 62--66)*.

Referrals to treatment or other health or social services should be voluntary and not required to avoid conviction or incarceration. Research has shown that mandatory or forced treatment does not generally lead to improved outcomes for people and in some cases can be potentially harmful *(67)*.

> It is still coercion. There is not much of a choice. Rehab or prison? It's virtually the same thing."
>
> - Community respondent

Participants in the community consultation advised that when treatment is an alternative to imprisonment or a fine it is coercive.

Treatment without voluntary consent also violates international human rights law. The Working Group on Arbitrary Detention has held that it contravenes the prohibition of arbitrary detention, violates the right to liberty and falls short of requirements for treatment to be voluntary *(4)*. OHCHR and WHO have provided extensive guidance on human rights in relation to mental health, including in relation to drug use and treatment *(68)*.

> Is there really any choice picking between prison and treatment?"
>
> - Community respondent

Referrals should only be made where evidence-based health services are available, appropriate and free or affordable. Decisions on any health-related intervention should be taken by the individual with the help of qualified health practitioners, rather than by police or other criminal justice actors.

The types of treatment or health services that form part of the referral system also vary, from counselling to abstinence programmes. Referrals to harm reduction services or initial counselling are preferred as they allow the individual to then decide with a health professional whether any further health services would be of benefit and, if so, what the individual would voluntarily like to undertake, if anything.

Success in treatment programmes, usually defined as abstinence—at least for a period of time during which the person is subject to monitoring by some authority—should not be considered a requirement for avoiding incarceration or further action.

Where failure in treatment is associated with a return to criminal proceedings or other sanctions, this can add significantly more stress and pressure to the

individual and undermine the benefits of any health services they may be accessing, including preventing people from accessing harm reduction services including NSPs or calling for help in case of an overdose.

Confiscation of drugs or drug paraphernalia, such as needles and syringes, by law enforcement is another common sanction, yet confiscation of either has been repeatedly found to increase rushed consumption, including needle sharing and increased risk of HIV and viral hepatitis *(26, 67, 69, 70)*.

Fines can also recreate the negative impacts of criminalization, with those from socio-economically deprived communities more likely to experience police contact and less likely to be able to afford this type of penalty. In some countries, the fines are extremely high and non-payment can quickly escalate to criminal proceedings and sometimes imprisonment. In some countries, treatment in lieu of payment of a fine is allowed, but this has the same negative impact as compulsory treatment orders *(4)*.

> For some people, administrative fees are preferable to jail. But poorer, more vulnerable populations experience the severity of the fees much more. It still marks the person's record and is still serious for people living in poverty."
>
> - Community respondent

Drug treatment registers are something which the Global Commission on HIV and the Law has recommended against, as it can deter people from seeking help and present serious challenges in terms of privacy, confidentiality and safety. They can also lead to deprivation of other rights such as education and work as some educational facilities or occupations may be closed to them *(48)*.

Although not discussed above, some decriminalized systems adopt an escalating approach with people who come before the court or similar entity repeatedly, subjecting them to increasingly punitive consequences, or where they only attract sanctions after a certain number of arrests, often known as a three-strike rule. Given that those who use drugs dependently are at greater risk of repeated police contact, and that most countries recognize dependency as a health issue, the decision by authorities to take an escalating approach is discriminatory on health grounds and contrary to international, and sometimes domestic, law.

Experience shows that other administrative consequences, such as fines or loss of social security, can have similar negative effects on health and other human rights as criminal sanctions.

> Sanctions, even if not criminal, were ultimately a way of criminalizing the poor. For example, by requiring a fine. Someone living on the street can't pay a fine.".
>
> - Community respondent

Evidence shows that it is not only the fear of conviction and prison that affects access to and use of harm reduction services, but any negative interaction with law enforcement and the criminal justice system, examples include confiscation of equipment or police harassment outside NSP sites *(26)*. As such, when making decisions in relation to the decriminalization of drug use and possession for personal use or other related laws, the minimization of unnecessary contact with the criminal justice system, including law enforcement, must remain a key consideration.

In addition, policing practices should be reviewed to ensure law enforcement actions do not create similar barriers to services; for example, activities such as stop and search where there is not reasonable suspicion of a more serious crime being committed or accessing health data from harm reduction clinics.

A no-sanction model, such as that implemented by the Netherlands and Spain for private consumption, avoids the negative impacts of non-criminal sanctions. Drug decriminalization has not been found to increase levels of drug use. There is nothing to indicate that the countries that have adopted a no-sanction model of decriminalization are seeing increased prevalence of drug use.

Indeed, in the case of the Netherlands, consumption of certain drugs appears to have decreased *(47)*. Such an approach does not preclude the provision of treatment and public health services, which can be done in a voluntary manner, with no obligations placed on the individual. As mentioned, the Netherlands has one of the lowest rates of HIV acquisition among people who inject drugs in Europe *(13)*. Given the resources that are expended on civil or administrative frameworks, although these are less resource intensive than criminal models, a no-sanction model would save further costs linked to policing, oversight and sanctioning *(71, 72)*.

> "You may have your driver's licence revoked or forbidden to go to certain places if you are caught in a neighbourhood where you buy and use drugs. The [dissuasion] commission can ban you from that neighbourhood, even if that is where you live. You can have social subsidies and benefits confiscated or annulled. It is a system which still punches down on poor people, on people without a safe place to use drugs privately."– Community respondent

The consensus in the community consultation was that a no-sanction model, as in the cases of Germany, the Netherlands and Uruguay, is best practice. Participants from countries where drug possession can attract administrative sanctions reported that these sanctions, while preferable to criminalization, still hinder access to health services, such as HIV treatment and weigh disproportionately on marginalized people, in particular homeless people and racialized people.

2.4.4 Good practice principles for alternatives to criminal sanctions

Drawing from the evidence and expert and community consultations, the following principles aim to ensure any decriminalized model promotes public health and specifically supports the HIV response, aligns with human rights obligations and recognizes the potential negative health and social consequences of specific responses.

> "There should be no sanctions and [any actions] should be self-led. For example, voluntary knowledge interventions and resource interventions, such as medical resources and voluntary services for people."
>
> - Community respondent

Good practice principles

- Any state response to the possession of drugs for personal use must support public health outcomes, comply with human rights obligations and not recreate the harms of criminalization.
- A no-sanction model removes barriers for people to access health and social support and improves their health and wellbeing and can help facilitate effective HIV responses and respect the rights of people who use drugs.
- Police and judicial system interaction should be minimized where possible.
- Where administrative sanctions are used, such as fines, they should not recreate the harms of criminalization or disproportionately affect certain groups, particularly those already marginalized.

- In models where penalties do exist, suspension of proceedings, with no further action after a short, specified period, should be incorporated.
- Confiscation of drugs and drug-related paraphernalia should be avoided as this can increase health harms and undermine law enforcement efforts as it contributes to rushed drug consumption and needle sharing.
- Referrals to treatment should be voluntary and only be used where treatment is readily available.
- Treatment plans and progress should be based on public health evidence and meet international human rights obligations of confidentiality and be overseen by health professionals only.
- Mandatory treatment, including but not limited to where it takes place in a detention setting, should be prohibited as this contravenes states' human rights obligations. Mandatory or coerced treatment is arbitrary in nature and operates in the absence of consent given freely, which is also contrary to the right to health.
- Escalated approaches, i.e. more severe sanctions for repeated offences should not be adopted as this penalizes people who are caught repeatedly in possession of drugs, which will often be people who experience drug dependency.
- Non-compliance with any penalty under a decriminalized model should not lead to more serious proceedings including criminal prosecution for non-compliance or create barriers to accessing harm reduction services.
- Administrative sanctions or treatment requirements should be monitored and reviewed regularly to ensure they support human rights and public health outcomes.

2.5 Decriminalizing harm reduction—drug paraphernalia laws

Drug paraphernalia laws involve criminalizing possession and supply of equipment that can be used to prepare, administer, use or test drugs. These laws can prohibit access to essential harm reduction tools such as sterile needles and syringes, other harm reduction equipment, naloxone, harm reduction information, leaflets and advice and may inadvertently criminalize providers of harm reduction services *(26, 73)*.

Some police practices will also indirectly criminalize the possession of drug paraphernalia; for example, checking syringes for drug residue, and charge the individual with drug possession. Some countries also specifically criminalize leaving drug paraphernalia in public places *(74)*.

Though some frameworks criminalizing drug paraphernalia make exceptions for authorized NSPs and participants, they still hinder access to drug paraphernalia *(74)*. This is despite sterile syringes and safer smoking kits;, for example, being proven to reduce the risks of overdose *(75)*, HIV transmission *(76)* and HCV transmission *(77)*. Where there are laws prohibiting possession of drug paraphernalia, evidence shows low access to NSPs *(78)*.

In 2004, WHO, UNODC and UNAIDS recommended the removal of legislation that criminalized the possession of drug paraphernalia, finding that such legislation is a barrier to effective HIV control for people who use drugs *(73, 79)*.

Confiscation of needles and syringes has been linked to increased needle sharing, higher prevalence of HIV and lower rates of attendance at HIV service providers *(26)*. Law reform in New York in the 1990s, which allowed for an NSP to operate despite drug paraphernalia laws, was associated with a reduction in HIV prevalence from 54% to 13% among people injecting and from 90% to 63% in HCV prevalence over the 1990–2001 period *(80)*. In Connecticut, reform to syringe laws was associated with to reduced syringe sharing and increased syringe sales *(81)*.

An effective national legal framework for reducing HIV risks among people who use drugs must, as a priority, ensure the lawful supply and possession of harm reduction equipment. Access to NSPs and other equipment should be as low barrier as possible and, at an absolute minimum, should involve repealing all relevant criminal laws related to drug paraphernalia. The tools decriminalized should go beyond only needles and syringes and include safer smoking kits, safer snorting kits and drug checking equipment.

Good practice principles

- People who use drugs must not be criminalized for using or possessing drug-related equipment, including indirectly by having their equipment tested for drug residue or being targeted for discarding used equipment beyond ordinary littering laws.
- Supply of harm reduction equipment should be legal.
- The use of civil laws to prohibit the carrying of drug paraphernalia should also be abolished in recognition that this can undermine public health goals.

The total decriminalization of both distribution and possession of drug paraphernalia is recommended by the International Guidelines on Human Rights and Drug Policy *(63)*, as well as by the UN Committee on Economic, Social and Cultural Rights *(82)*, the 2006 International Guidelines on HIV/AIDS and Human Rights *(83)*, the Working Group of Arbitrary Detention *(4)* and the Global Commission on HIV and the Law *(48)*.

2.6 Laws prohibiting public drug use

> Criminalizing public drug use, but not other drug use, is criminalizing the poor."
>
> - Community respondent.

In some approaches to the the decriminalization of drug use and possession for personal use, where private use does not attract state action, public use or possession can still attract administrative or criminal sanctions. The consequence of this approach is that marginalized people, many of whom cannot use drugs in the privacy of a home for a wide variety of reasons, continue to be disproportionately targeted by drug laws and drug law enforcement and are excluded from drug law reform *(84, 85)*. Some national constitutional courts have ruled that criminalization related to public consumption violates constitutionally recognized rights to privacy *(86–88)*.

In the community consultation, participants flagged the negative and exclusionary impacts of criminalizing public drug use, advising that it leads to continued police harassment and barriers to health and harm reduction services.

People who are homeless have no choice but to use drugs in public spaces, with fear of sanctions often leading to rushed consumption and so higher risks of needle sharing if they fear arrest, and many people who use drugs face housing discrimination, which drives homelessness rates.

Likewise, people in precarious living situations, such as rented accommodation or hostels, may not be able to consume drugs in private due to risks of eviction or harassment for drug use. Finally, there may be reasons, especially for women, young people and children, that drug use in the private home is not feasible or safe.

> People who choose to use drugs publicly have very few other options as to where they can use them, especially when it comes to stigmatized drugs like heroin, fentanyl, methamphetamines and cocaine."
>
> - Community respondent

Ensuring spaces to use drugs safely is critical to improving HIV outcomes as well as protecting people's right to health. This will include opening space for community dialogue to find sustainable solutions that effectively incorporate legitimate concerns about public health, which may include DCRs, social clubs where people can use their drugs in private and housing justice.

Canada. British Columbia. The model of decriminalization in British Columbia allows for the possession of certain drugs below 2.5 grams in certain locations. This includes private residences, places where people who are unhoused are legally allowed to shelter, outpatient drug services and overdose prevention or supervised consumption sites and drug checking services *(89)*.

In these spaces, police are not allowed to seize drugs, arrest or charge people who are aged 18 or over, but police can provide information on health services. Where people are using drugs in public, police can confiscate the drugs and ask them to leave the area, failure to comply can lead to arrest *(89)*.

The provision related to public drug use was only introduced in 2024, largely in response to the crisis of homelessness and there are concerns that this new law could undermine the decriminalization efforts more broadly *(90)*.

The INCB has noted the effectiveness of DCRs to reduce the negative health and social consequences of injecting drug use *(91)*. The INCB has also cited evidence for DCRs showing that they can "succeed in attracting hard-to-reach populations, promoting safer injections, reducing the risk of overdose and decreasing public drug injections, discarded syringes, and other drug-related litter in the community." *(91)* It is estimated that an average of 35 HIV infections a year are averted by the existence of a DCR in Vancouver *(92)*.

Good practice principle

Public drug use should not be a crime, nor should it be punished as a civil offence. Rather support for the creation of spaces, such as DCRs should be prioritized, as well as addressing underlying causes of precarious housing situations.

2.7 Expungement of criminal records

Some countries that have decriminalized or legalized drugs have expunged the criminal records of those people convicted of offences that have been decriminalized. International human rights law recognizes the right to benefit from a lighter penalty if legal reforms reduce or repeal penalties for an offence after the crime was committed. The Human Rights Committee confirmed this position when determining the remit of Article 15 of the International Covenant on Civil and Political Rights *(93)*.

Expungement means that people no longer have a criminal record for a particular offence. Given the stigma that can be associated with a criminal record, and the barriers it can place on rights to non-discrimination in employment, access to social and economic rights, including access to housing or education or on international mobility, it is an important element in the decriminalization process.

> Most people caught in possession of drugs are subject to criminal charges, so they get criminal records, thus suffering a huge social impact."
>
> - Community respondent

It is a feature of many cannabis legalization frameworks in the USA, but it is also a feature of cannabis decriminalization frameworks in Belize and Caribbean countries. Expungement mechanisms may permit automatic expungement, while some require an application and fee, which can be a barrier to people without financial resources.

Good practice principle

Countries considering the decriminalization of drug use and possession for personal use should introduce a process to review convictions and sentences for such offences and, where appropriate, quash, commute or reduce existing convictions and/or sentences. *(94)*.

2.8 Adolescents, young people and the decriminalization of drug use and possession for personal use

Most models of decriminalization focus on adult drug use and possession for personal use, with many retaining criminal penalties for young people caught in possession of drugs. for personal use This can be harmful and inequitable given the damage criminalization, including acquiring HIV and viral hepatitis, and the effects of a criminal record can have on young people. In terms of harm reduction services, this can be an added barrier to accessing such services.

A special analysis by UNAIDS in 2020 found that 10% of new infections in Asia Pacific among young people were among people who inject drugs, with HIV prevalence above 15% in two of the countries studied *(95)*. A study of self-assessed HIV risk among young people aged 15–-24 in Indonesia found that 34% of those interviewed who inject drugs assessed themselves at high risk for HIV and another 26% assessed themselves at some risk. Among those interviewed, 59% reported sharing needles in the last month and only 27% had heard of OAMT *(96)*.

International human rights law requires that the best interests of the child be a paramount consideration in any policies or programmes relating to children. States have an obligation to take appropriate measures to protect children from the risks and harms of drugs and drug policies. As noted by the Committee on the Rights of the Child, appropriate measures must be evidence based and conform to international human rights norms, including ensuring they do not undermine the right to health. For more than two decades, the Committee on the Rights of the Child has emphasized the importance of the decriminalization of drug use and possession for personal use as a means to supporting the full realization of the rights of the child *(63, 97, 98)*.

As such, international human rights standards mandate that states ensure adequate availability and accessibility of prevention, harm reduction and treatment services specifically tailored to the needs of children, avoid excluding children from school on the basis of drug use and also ensure children are diverted from criminal justice systems whenever possible, with a focus on providing support and to refrain from criminalizing children due to drug use and possession *(63)*.

UN treaty bodies have,

> "… recommended that States strengthen measures to provide children and adolescents with information on the harmful effects of drug abuse as well as life-skills education on preventing substance abuse, develop accessible and youth-friendly drug dependence treatment and harm reduction services according to their age and background, develop protocols for the early identification and adequate referral of adolescents requiring treatment, improve the quality of rehabilitation services by developing effectiveness criteria and monitoring the quality of services, and ensure that procedural safeguards, including access to the file and the provision of legal assistance, are respected for all children, including those arrested on drugs charges." *(94)*

As noted by UNICEF and UNODC, there is a need to move away from punitive measures to developmentally appropriate, contextually relevant and evidence-based interventions for young people facing adversity *(99)*.

> "UNICEF advocates for developmentally appropriate, contextually relevant and evidence-based interventions that move away from punitive measures and focus on early intervention, harm reduction and support. We also emphasize the need to address the underlying social, economic and environmental factors that contribute to drug use among youth … Young people who use drugs must also be actively involved in decision-making processes that affect their lives." *(100)*

In terms of criminal matters, the Committee on the Rights of the Child recommends that the age of criminal responsibility should take into account the emotional and intellectual maturity of the child, indicating it should not be set at anything lower than 14 or 16 years *(101)*. For those over the age of criminal responsibility, the decriminalization of drug use and possession for personal use should apply. In Switzerland, a 2019 federal court found that children caught in possession of cannabis should be treated exactly the same as adults under their decriminalized framework and be subject to a fine *(102)*.

Likewise, forced treatment or treatment detention should be avoided as these are a human-rights violation and public health concern *(103)*. This applies equally to all persons regardless of their incarceration status.

The few studies that have looked at HIV risk behaviours among young people who use drugs (14–-15 to 25 years of age) have generally shown high rates of syringe sharing and borrowing *(104)*. Harm reduction services should be fully accessible to young people and should be youth specific, providing age-appropriate resources, supervised spaces, accurate information and non-punitive support *(103)*. However, criminalization may deter harm-reduction service providers from offering assistance, including concerns about their own legal liability, as age barriers often exist to accessing services *(103)*.

Of the 13 countries reporting to UNAIDS since 2022 that adolescents are allowed to access NSP, only seven had laws allowing people under the age of

18 to access NSPs without parental consent. In six out of 21 countries reporting that adolescents are allowed to access opioid agonist maintenance therapy, adolescents under 18 could access opioid agonist maintenance therapy without parental consent *(105)*. Integrated services that provide access to HIV testing, counselling and treatment alongside substance use prevention, drug overdose education and mental health support are vital in reducing HIV transmission rates and improving overall health outcomes for young people.

> "Governments have a legal obligation to respect, protect and fulfil the rights of children to life, health and development, and indeed, societies share an ethical duty to ensure this for all young people. This includes taking steps to lower their risk of acquiring HIV, while developing and strengthening protective systems to reduce their vulnerability. However, in many cases, young people from key populations are made more vulnerable by policies and laws that demean, criminalize or penalize them or their behaviours and by education and health systems that ignore or reject them and that fail to provide the information and treatment they need to keep themselves safe." *(103)*

Good practice principle

- Children and adolescents should not be criminalized for drug use or possession for personal use. Adolescents who have reached the age of criminal responsibility should benefit from decriminalization models.
- Students should not be expelled from school for any drug related activity and any treatment should be voluntary.
- Harm reduction services should be available to adolescents and young people and should be youth specific

Conclusion

Punitive so-called "war on drugs" approaches to drug use have not only failed to reduce the supply and demand for illicit drugs, it has caused significant and in some cases fatal harm to people who use drugs. Rates of HIV and viral hepatitis remain high among people who use drugs, and overdose deaths continue to rise.

The decriminalization of drug use is a necessary element in creating the enabling legal environment required for ending AIDS as a public health threat for everyone.

In developing a model of decriminalization of drug use and possession for personal use, it is imperative to maximize the impact of the framework, properly reducing risks associated with HIV transmission and barriers to accessing care to ensure the process of decriminalization does not replicate the harms of punitive approaches.

By exploring the experiences of other countries, and how they have implemented the decriminalization of drug use and possession for personal use, the *Guidance note* helps inform policy design, processes and implementation. It is important to note that not all models of decriminalization are effective at upholding human rights and supporting the HIV response; in fact, some simply replicate the harms of criminalization.

Key to this is creating models that are developed in partnership with communities themselves, are rights and public health-based and non-discriminatory, encompass all drugs and paraphernalia, provide clarity to people who use drugs, reduce the role of law enforcement, avoid punishing people and allow access to voluntary, evidence-based harm reduction and treatment. Monitoring and evaluation of implementation, in collaboration with communities is key to ensuring that implementation continues to meet the aims of decriminalization, including the reduction on HIV acquisition among people who use drugs.,

Decriminalization must go hand in hand with efforts to combat stigma and discrimination, and with the provision of inclusive, accessible, affordable and acceptable HIV prevention, treatment, care and support services. In fact, decriminalization can be an important pre-condition for the quality and effectiveness of these services.

The decriminalization of drug use and possession for personal use in the context of HIV is not just about removing criminal laws and penalties, it is about fostering dignity, equity and justice for all individuals affected by drug policies. By embracing this shift, countries can accelerate progress toward ending AIDS as a public health threat by 2030 and uphold their commitments to health, human rights and social justice.

Annex 1. Methodology

This study was undertaken using a range of methods and resources.

Legal and policy review

Desk-based legal scans have been conducted and a preliminary qualitative analysis undertaken to position the various approaches to the decriminalization of drug use and possession for personal use alongside HIV outcomes and obligations contained within various human rights instruments.

To understand the national legal and policy environment, a legal scan was undertaken to analyse both reform pathways and national laws related to the decriminalization of drug use and possession for personal use. Relevant country examples were reviewed in addition to research undertaken by other international agencies, peer-reviewed scholarship and organizations. Shadow reports, Member State reports and concluding observations and reports from UN human rights mechanisms were also consulted.

Surveys

Surveys were completed by 16 UNAIDS country offices across five regions, providing information related to the laws, policies and practices around the decriminalization of drug use and possession for personal use.

Consultations and the importance of lived experience

A series of consultations and discussions were undertaken with a range of community organizations of people who use drugs, civil society groups, UN country teams and a globally diverse group of experts on HIV, public health, human rights and drug policy, to help inform and guide the research as it developed. Those consulted included subject matter experts on international human rights law, drug policy reform, HIV/AIDS, etc. These consultations helped guide the research, identify legal materials and capture socio-legal reflections from around the world. All information was anonymized to ensure confidentiality.

The importance of lived experience

To ensure the *Guidance note* reflects the lived or living experience of people who use drugs, its development was led by the INPUD. INPUD co-produced the methodology with UNAIDS and a consortium of community stakeholders. A diversity of organizations of people who use drugs were consulted to confirm findings, understand national conversations and work being undertaken on the issue and to bear witness to the deeply unjust harm occurring around the world. Wherever possible, scholarship and advocacy produced by people with lived experience was used to ensure epistemic justice.

Limitations

A limitation of the methodology was the desk-based research being restricted to English-language publications only. This was mitigated somewhat through the global reach of our consultations and advisory community. Further, not all country examples had undergone an implementation review or analysis, which is likely due to a combination of political, resource and other practical reasons. This means that many of the studies produced are limited to Global North countries, hence a large portion of the research is limited to cannabis decriminalization only. While the aim of the methodology was to be expansive and comprehensive in gathering country experiences in decriminalization, the countries featured in the *Guidance note* in no way implies that they represent a best practice nor that there are no other good practices from other countries. It is hoped that by the consultative nature of the research, the *Guidance note* has been able to overcome some of these gaps in the literature supplemented by lived experiences, technical reports from the UN family and other grey literature.

Role of community in producing the Guidance note

INPUD, UNAIDS, Release UK and the University of Essex held three in-depth consultations that shaped the direction and content of the *Guidance note*, as well as the fine-tuning of its progressive iterations.

The first was a community consultation held on 2 October 2024, led by INPUD. The consultation was attended by 40 drug user activists, advocates and representatives, who were primarily drawn from countries that have decriminalization on record, including Portugal, Costa Rica, Mexico, Kyrgyzstan and Poland, including people from UNAIDS Fast-Track countries.

Respondents were geographically and gender diverse and drawn from the population that have the lived experience of life under different decriminalization models as well as criminalization, allowing for the emergence of common themes and principles to feed into the guidance on drug policy reform.

Virtual focus groups enabled community members to provide inputs, perspectives and experiences on TQs, sanctions and determination of offence.

Finally, respondents shared feedback on the first draft of the *Guidance note* which. were collated and shared with the consultants responsible for drafting the *Guidance note* to incorporate into subsequent drafts.

Following this, a consultation was organized across all four organizations on 21 October 2025, was held with a broad audience comprised of 41 community representatives, UN officials, academics and researchers and civil society organizations, including youth representatives. The group structure was geographically, gender and age diverse, including people from other key populations and people living with HIV.

Virtual focus groups were held among the respondents to review and provide feedback on the first draft of the *Guidance note*on drug policy reform, inputting

on its approach and methodology, structure, identification of gaps and missing topics and/issues and approach to partial decriminalization of drug use and possession for personal use thus far.

Specific inputs on decriminalization models were sought;, in particular, TQs, sanctions and determination of offences. People were asked to provide good examples of decriminalization of drug use and possession for personal use around the world, missing research to bolster the evidence base and input into what optimal models and practices look like.

Finally, on 9 December 2024 the same group as above was convened, with Release UK leading the discussions to solicit inputs on the second draft of the *Guidance note*. Feedback was sought on the changes made to the second draft and the final version of the report, as well as asking for guidance on the tone and style of the *Guidance note*, its utility as a technical document the principles, and to identify any missing topics and issues.

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PART 2

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